Pohjola Insurance

Insurance for yourself and your loved ones

Extrasure Insurance Terms and Conditions, valid as of 1 April 2022

CONTENTS

PERSONAL INSURANCE

The Extrasure insurance cover may include the following types of personal insurance

- Health Insurance
- Living Allowance Insurance
- Life Insurance
- Disability Insurance
- Pohjola Traveller's Insurance.

The insurance cover selected for each insured person is stated in the policy document.

Common provisions for personal insurance

These common provisions are applied to Health Insurance, Living Allowance Insurance, Life Insurance and Disability Insurance.

The terms and conditions of Pohjola Traveller's Insurance can be found in the Travel insurance section.

1 Insured Person

Those insured are the persons named in the insurance policy.

2 Beneficiary

The policyholder may name a beneficiary to whom any compensation is paid. Such a beneficiary clause and relevant alterations or cancellations affecting it must be submitted to the insurance company in writing.

Compensation from Health Insurance and Living Allowance Insurance, with the exception of Death Cover, is paid to the insured person, unless the policyholder has determined another beneficiary.

When the insured person is a foetus, the beneficiary in a Health Insurance policy is the mother until the child's birth. When the insured person is a foetus, the beneficiary under Death Cover included in Living Allowance Insurance is the policyholder.

3 Validity of insurance

3.1 Territorial limits

The insurance cover is valid worldwide.

Compensation from Health Insurance is, however, only paid for costs arising in Finland. If it has been separately agreed on and entered under some Health Insurance cover that compensation may also be paid for expenses incurred abroad, we nevertheless only accept expenses incurred in the EU and EEA area and Switzerland. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

3.2 Validity during sports

In motor sports, motor liability insurance is the primary source of compensation, as against Health Insurance.

3.2.1 Definition of competitive sports

Competitive sports refer to competitions or matches arranged by a sports association or club, training arranged according to a training programme, and other training typical of the sport, regardless of the level of competitiveness or the age of the insured person. In Athletes' Medical Treatment Cover, Athletes' Supplementary Medical Treatment Cover and Athletes' Dental Cover, competitive sports also include the journeys to and from the above games, competitions and training.

Training arranged according to a training programme refers to training carried out following either a written or verbal training plan (the coach does not have to be present).

Other training typical of the sport refers to training that supplements the main sport when carried out as part of preparation to games or sports.

3.2.2 Competitive sports

The following do not apply to competitive sports: Health Insurance Medical Treatment Cover, Cost Cover, Supplementary Medical Treatment Cover and Dental Cover, Living Allowance Insurance Daily Allowance Cover and Disability Insurance.

However, Living Allowance Insurance Disability Cover and Death Cover are valid in competitive sports. Life Insurance is also valid in competitive sports.

Health Insurance Athletes' Medical Treatment Cover, Athletes' Supplementary Medical Treatment Cover and Athletes' Dental Cover are valid in those competitive sports which have been entered in the insurance policy. They are nevertheless never valid for high-risk sport competitions referred to in clause 3.2.4.

Neither are the covers valid in adult competitive sports at the two highest national levels in football, ice hockey or volleyball, nor at the highest level of junior ice hockey.

If separately agreed and recorded in the Disability Insurance policy document, the policy is nevertheless valid in competitive sports, but never with high-risk sports defined in clause 3.2.4.

3.2.3 Special sports

Health Insurance Medical Treatment Cover, Cost Cover, Supplementary Medical Treatment Cover and Dental Cover, Living Allowance Insurance Daily Allowance Cover, and Disability Insurance do not apply to the sports listed below. In these terms and conditions, we call them special sports. The above applies regardless of whether the insured person is competing in any of the sports or not.

However, Living Allowance Insurance Disability Cover and Death Cover are valid in special sports. Life Insurance is also valid is special sports.

Health Insurance Athletes' Medical Treatment Cover, Athletes' Supplementary Medical Treatment Cover and Athletes' Dental Cover are valid in the special sports listed below when the appropriate entry has been made in the insurance policy. Coverage is also extended to immediate journeys to and from the place where such special sports are done. However, the insurance is not valid for competi-

tions in such special sports. Competitive sports have been specified in clause 3.2.1.

If it has been separately agreed and the appropriate entry has been made with reference to Disability Insurance, the insurance is nevertheless valid in all the special sports listed below. However, the insurance is never valid for competitions in such special sports. Competitive sports have been specified in clause 3.2.1.

Special sports are:

- combat sports, self-defence sports and martial arts
- winter sports: luge and freestyle skiing as well as speed and downhill skiing
- aviation, such as hot air and gas ballooning, motorised flying, hang- and paragliding, microlight flying, parachuting, indoor skydiving, flying with amateur-built aircraft, and use of gliders and motor gliders
- Strength sports: powerlifting, weightlifting and body building
- scuba diving
- other special sports: BMX cycling, bungee jumping, parasailing, skimbat or kite surfing, sailboarding and flyboarding, parkour, abseiling, acrobatics and free running.

3.2.4 High-risk sports

Health Insurance Medical Treatment Cover, Cost Cover, Supplementary Medical Treatment Expenses Cover and Dental Cover, Living Allowance Insurance's Daily Allowance Cover, and Disability Insurance do not apply to the sports listed below. In these terms and conditions, we call them high-risk sports. The above applies regardless of whether the insured person is competing in any of the sports or not.

However, Living Allowance Insurance Disability Cover and Death Cover are valid in high-risk sports. Life Insurance is also valid in high-risk sports.

Health Insurance-based Athletes' Medical Treatment Cover, Athletes' Supplementary Medical Treatment Cover and Athletes' Dental Cover are valid in the high-risk sports listed below which have been entered in the insurance policy. Coverage also extends to immediate journeys to and from training of the sport and in competitions in the sport. Competitive sports have been specified in clause 3.2.1.

If it has been separately agreed and the appropriate entry has been made with reference to Disability Insurance, the insurance is nevertheless valid in all the high-risk sports listed below. This means that Disability Insurance will also be valid in competitions of high-risk sports. Competitive sports have been specified in clause 3.2.1.

High-risk sports are:

- American football
- Australian football
- Rugby
- Lacrosse
- Mixed Martial Arts
- Wrestling
- Off piste skiing
- Ice and rock climbing
- Glacier and mountain climbing
- Strength athletics
- Downhill biking
- Downhill skating
- Ocean sailing
- BASE jumping
- Trekking into uninhabited areas, such as research expeditions or treks to mountains, jungles, deserts or wilds or other similar areas abroad
- Wildwater canoeing
- Freediving
- Roller derby
- Other sports where the risks are at a similar level.

3.3 Effect of the insured person's age on validity

The insurance cover will expire at the end of the insurance period during which the insured person reaches the age of 100. However, Life Insurance and Disability Insurance and Living Allowance Insurance Daily Allowance Cover end before that, as specified in their terms and conditions. Moreover, Health Insurance Dental Cover ends in terms of illnesses earlier, as specified in the insurance policy.

4 Accident and exclusions

4.1 Accident

An accident is a sudden, external occurrence which is beyond the control of the insured person and which causes bodily injury.

The following are also considered to be accidents: unintentional drowning, heat stroke, sunstroke, frostbite, injury caused by a considerable variation in atmospheric pressure, gas poisoning sustained by the insured person, and poisoning caused by a substance taken inadvertently.

4.2 Exertion and its exclusions

Health Insurance Athletes' Medical Treatment Cover and Athletes' Supplementary Medical Treatment Cover taken out in the case of accidents will also compensate a strain or rupture injury in a muscle or ligament, verified by a doctor, caused in connection with exertion when engaging in a competitive sport, high-risk sport or special sport referred to in the insurance policy and for which medical treatment has been given within 14 days of the strain or rupture.

Costs caused by exertion will be reimbursed for up to six weeks from the beginning of treatment. These costs may include one MRI examination. Surgical operations are not compensated.

The compensation of strain or rupture injury caused by exertion has the same restrictions as with accidents. Injuries that are not covered under clause 4.3 will not be covered if caused by an exertion, either. Clause 4.4 is also applied to injuries caused by exertion in the same way as to accidents.

4.3 Injuries which are not covered

The concept 'accident' does not include injury caused by

- an event arising from an illness, defect or injury of the insured

- operation, treatment or other medical procedure, unless the procedure is undertaken for the treatment of an injury coverable under the same insurance
- poisoning due to medicine, alcohol or other intoxicant used by the insured, or due to a substance taken as food
- Injury to a tooth or dentures caused by biting, even if an external factor has contributed to the damage
- suicide or attempted suicide.

Infectious diseases caused by a bite or sting are not compensated as an accident.

We will not compensate as an accident a hernia of the intervertebral disk, abdominal or inguinal hernia, the rupture of an Achilles tendon, long head of biceps tendon or rotator cuff, or recurrent dislocation, unless the injury was caused by an accident that would also cause injury to healthy tissues.

4.4 Effect of illness, injury, defect or degeneration not related to the accident

The insurance does not cover illness, injury, defect or degeneration of the musculoskeletal system which are not related to an accident, even if symptomless before the accident.

If the above factors not related to the accident have materially contributed to the emergence of the injury or its delayed recovery after the accident, compensation is only paid insofar as the expenses, disability or permanent handicap are deemed to have been caused by the accident. This restriction does not apply to the Death Cover included in Living Allowance Insurance.

4.5 Extension for accidents

This clause is applied to Health Insurance Medical Treatment Cover, Cost Cover and Supplementary Medical Treatment Cover if the insured person was 60 years old or more at the time of the accident.

Accident expenses are also reimbursed when an accident has taken place because of an illness, defect or injury. However, expenses for the illness, defect or injury are not reimbursed as accident expenses.

Costs caused by an accident are reimbursed in addition to a period in which conventional medicine considers that recovery should have been made for another four months at the most, when an illness, defect, injury or musculoskeletal degeneration unrelated to the accident has make recovery take longer. We do not reimburse, as accident costs, any costs that are the result of delayed recovery owing to illness, defect, injury or musculoskeletal degeneration.

Costs caused by an accident are reimbursed for a maximum of four months, when an illness, defect, injury or musculoskeletal degeneration unrelated to the accident has materially contributed to the occurrence of the accident. However, costs of an illness, defect, injury or musculoskeletal degeneration that materially contributed to the accident will not be reimbursed as accident costs.

5 Reasonableness of expenses

If it becomes evident that the expenses for which indemnity is claimed clearly exceed the generally accepted and reasonable level, the insurance company has the right to lower the amount of indemnity, but not below the reasonable level.

6 Insurance company's right to decide on place of treatment

The insurance company has the right to decide where the insured person's examinations and treatment are carried out, provided this does not cause unreasonable inconvenience to the person.

7 High-risk areas, war, nuclear accident and aviation accident

7.1 Health Insurance and Living Allowance Insurance

Compensation is not paid if the accident occurred or the insured person fell ill in a country or part of the country which the Ministry for Foreign Affairs of Finland recommends avoiding travelling to, or which the Ministry for Foreign Affairs of Finland recommends leaving. However, this exclusion will not apply

- during ten days from the date of such recommendation if the insured person has arrived in the country or a part of the country described above before the Ministry for Foreign Affairs' recommendation, unless a major war is concerned or the insured person has participated in the war or an armed conflict or the insured person has participated in peacekeeping operations organised by the United Nations, the European Union or another community or organisation, or in connection with some other military operation
- if the insured person's illness, injury or death is not due to the reason why the Ministry for Foreign Affairs issued its recommendation.

Cover is not provided for any illness, injury or death caused by a war or armed conflict in Finland. This exclusion will not apply during the 10 days from the beginning of armed operations, unless a major war is concerned or the insured person participated in a war or armed conflict.

Cover is not provided for any illness, injury or death caused by a nuclear accident as described in the Nuclear Liability Act, or caused by material, equipment or weapons based on nuclear reaction or ionising radiation, regardless of where the nuclear accident occurred.

Compensation is not paid from Health Insurance or Living Allowance Insurance if an illness, injury or death has been caused in hobby or professional aviation to a pilot or other member of the flight crew or person carrying out duties related to a flight. Aviation sports, however, may be insured separately as special sports in accordance with clause 3.2.3 of the terms and conditions of traveller's insurance. However, special sports do not cover professional aviation.

7.2 Life and Disability Insurance

Cover is not provided from Life or Disability Insurance for any illness, injury or death caused by a war or armed conflict. This exclusion will not apply during the 10 days from the beginning of armed operations, unless a major war is

concerned or the insured person participated in a war or armed conflict.

If an extension for war risk has been agreed on separately and an entry of this has been made in the Life Insurance policy, the insurance will be valid also in the case of war or armed conflict. Extending the cover to include war risk area does not, however, extend the cover for a major war or situations in which the insured person participated in the war or an armed conflict.

Moreover, cover is not provided from Life and Disability Insurance if any illness, injury or death was caused by a nuclear accident as described in the Nuclear Liability Act, or caused by material, equipment or weapons based on nuclear reaction or ionising radiation, regardless of where the nuclear accident occurred.

8 Taxes and fees payable by policyholder owing to a move abroad

If the policyholder has moved abroad, resulting in direct or indirect taxes or other fees through legislation or official regulations payable by the insurance company, the latter is entitled to collect such taxes or fees from the policyholder.

9 Applicability of General Contract Terms and Conditions

The General Contract Terms and Conditions are applied in all insurance policies.

HEALTH INSURANCE

1 Insurance coverage

The following types of coverage are available:

- Medical Treatment Cover
- Cost Cover
- Supplementary Medical Treatment Cover
- Dental Cover
- Fitness Cover
- Athletes' Medical Treatment Cover
- Athletes' Supplementary Medical Treatment Cover
- Athletes' Dental Cover.

The types of cover for each insured person are stated in the policy document.

2 Medical Treatment Cover

2.1 Key contents of insurance cover

Insurance can be taken out against

A accidents and illnesses

This option compensates expenses to the insured person caused by accident or illness as specified in these terms and conditions.

B accidents and the following illnesses

- strain or rupture of a tendon, tendinitis or degeneration of tendon
- muscle strain or rupture
- herniation of intervertebral disk
- abdominal, umbilical or groin hernia
- rupture of meniscus in the knee, and
- dislocation of joint or kneecap.

This option compensates expenses to the insured person caused by accident or illness listed above as specified in these terms and conditions.

C accidents

This option compensates expenses to the insured person only caused by an accident as specified in these terms and conditions.

The insurance policy indicates which of the three options above has been chosen.

Compensation is only payable if the expenses are incurred while the policy is in force. If the expenses are caused by an accident, the accident must also have occurred during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

During the validity of the insurance cover, expenses are covered up to a maximum compensation indicated in the insurance policy. The maximum compensation is subtracted with all compensation paid from the insurance. Insurance coverage ends when the maximum amount of compensation has been paid.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for.

Compensation is only paid for examination carried out or treatment provided in Finland or for an acquisition made in Finland. If it has been separately agreed and the appropriate entry has been made in the policy, such examinations, treatments or acquisitions may also be covered abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

2.2 Coverable expenses

The condition for compensation to be paid is that the incident concerns an illness or injury that is coverable under Medical Treatment Cover. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- fees for examination and treatment procedures carried out by physicians and healthcare professionals at their practice or clinic

- costs of pharmaceutical products and wound dressings sold at pharmacies
- daily hospital charges. If it has been separately agreed on and entered in the policy that expenses incurred abroad will also be reimbursed, the number of daily hospital charges specified in the insurance policy will be reimbursed.
- costs of an orthopaedic brace if it was the first orthopaedic brace acquired after a coverable operation or accident. These expenses are only covered up to EUR 500 per operation or accident
- rental costs of forearm or underarm crutches.

When the insured is a child, the coverable expenses are specified in clause 2.2.1.

2.2.1 Coverable expenses when the insured is a foetus

When the insured is a foetus, this clause applies until birth.

The condition for compensation to be paid is that the incident concerns an illness or injury that is coverable under Medical Treatment Cover. What is more, the illness or injury examination or treatment must have been prescribed by a physician and be in accordance with generally accepted medical practice. Moreover, the examination or treatment must be caused by pregnancy alone and necessary by the child's health.

Of these expenses, we cover the mother's pre-natal

- public health care outpatient clinic fees
- costs of pharmaceutical products and wound dressings sold at pharmacies
- public health care daily hospital charges.

2.3 Expenses which are not covered

Expenses are not reimbursed if they are caused by

- expenses arising from the examination or treatment provided by a physiotherapist, foot therapist, chiropractor, osteopath, naprapathy practitioner, masseur or equivalent healthcare professional
- acupuncture or lymphatic therapy
- examination or treatment by a nutritional therapist or equivalent healthcare professional
- examination or treatment by an occupational or speech therapist, psychologist, neuropsychologist or other equivalent healthcare professional
- psychotherapy or equivalent examination or treatment
- examination or treatment by a dentist, specialised dentist, dental hygienist or dental technician
- pregnancy, childbirth, termination of pregnancy or examination or treatment of infertility or from complications caused by these events or conditions
- refractive error operation or other treatment or aid relating to the correcting of refractive errors
- cataract operation
- examination or treatment by an optician or equivalent healthcare professional
- purchase of micronutrients, minerals or vitamin preparations, unless they are considered pharmaceutical products
- purchase of nutritional products including clinical nutritional products
- basic creams or lotions or equivalent, unless they are used for treating an accidental injury
- purchase of anthroposophic or homeopathic products
- examination or treatment related to outward appearance or looks
- examinations or treatments related to breast reduction, enlargement or modification, skin peeling or dermabrasion or the lifting or rejuvenation of eyelids, areas around the eyes or other facial feature
- reconstruction of a lost body part
- medicinal treatment of obesity, liposuction, gastric bypass or sleeve operation or other weight-loss surgery or other obesity examination and treatment
- expenses arising from the examination or treatment of transsexuality
- varicose vein removal or other varicose vein treatment
- treatment whose primary reason is to improve the person's quality of life; this includes medication that enhances sexual performance. This restriction is not applied, however, in the case of pharmaceutical products that have been compensated under the Health Insurance Act.
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction
- medical equipment or other aids, orthotic insole or other insole or artificial limb (however, the rental costs of forearm or underarm crutches are reimbursed)
- costs of an orthopaedic brace unless it was the first orthopaedic brace acquired after a coverable operation or accident. In cases like this, too, these expenses are only covered up to EUR 500 per operation or accident.
- treatment for snoring, unless the treatment concerns sleep apnoea verified by means of sleep registration
- mole removal
- examination made or treatment given in the insured person's home, other house call and other than a practice or clinic
- spending time or staying at a place providing rehabilitation services or any actual services used
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

Expenses that are not indemnified when the insured person in a foetus are listed in clause 2.3.1.

2.3.1 Non-coverable expenses when the insured is a foetus

When the insured is a foetus, this clause applies until birth.

Pre-natal expenses are not reimbursed if they are caused by

- childbirth
- examination or treatment by a dentist, specialised dentist, dental hygienist or dental technician
- purchase of nutritional products including clinical nutritional products
- purchase of micronutrients, minerals or vitamin preparations, unless they are considered pharmaceutical products
- purchase of anthroposophic or homeopathic products.

Neither are expenses covered if they are caused by the abuse of a medicinal product or the use of alcohol or intoxicant by the mother of the insured child.

The above expenses are not covered even if an examination and treatment that cause these expenses were necessary for the foetus.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

2.4 Filing a claim

2.4.1 Notification of illness or accident

The claimant shall submit to the insurance company a written clarification of any illnesses, accidents, examinations, treatments and aids. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

Fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

2.4.2 Receipts

The claimant must pay the medical treatment expenses him/herself before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

2.5 Other applicable terms and conditions

The common provisions for personal insurance are applied.

3 Cost Cover

3.1 Key contents of insurance cover

The following types of cover may be selected

- doctors' fees and examination expenses
- surgery and special examination expenses.

The insurance policy shows which of the above have been chosen.

The above expenses may be coverable

A accidents and illnesses

> In this option we compensate expenses specified below caused by the insured person's accident or illness.

B against accidents

> In this option we compensate expenses specified below caused by the insured person's accident.

It has been entered in the insurance policy which option has been chosen.

3.2 Entitlement to compensation

Compensation is only payable if the expenses are incurred while the policy is in force. If the expenses are caused by an accident, the accident must also have occurred during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

Each selected expense item has a maximum amount of indemnity entered in the insurance policy, which will not be exceeded during the validity of the insurance cover. Any compensation paid will reduce the remaining amount of indemnity that may be paid. Once the maximum compensation has been reached, coverage ends.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for.

Compensation is only paid for examination carried out or treatment provided in Finland or for an acquisition made in Finland. If it has been separately agreed and the appropriate entry has been made in the policy concerning a certain type of expense, such examinations, treatments or acquisitions may also be covered abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

3.3 Coverable expenses

3.3.1 Doctors' fees and examination expenses

The condition for compensation to be paid is that it concerns an illness or injury that is coverable for doctors' fees and examination expenses. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- fees for examination and treatment procedures carried out by physicians and nurses at a practice or clinic
- fees for examinations performed by health care professionals at their practice or clinic prescribed by a physician.

Expenses are not reimbursed if they are caused by

- surgical procedure or endoscopy
- MRI examination or computed tomography
- pharmaceutical product or other product
- orthopaedic brace or bandage, wound dressings, orthotic insole or other insole or other equipment or instrument
- medical equipment or artificial limb
- daily hospital charges.

In addition to the above, restrictions in section 3.4 also apply.

3.3.2 Surgery and special examination expenses

The condition for compensation to be paid is that it concerns an illness or injury that is coverable for surgery and special examination expenses. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- fees for surgical operations
- daily hospital charges immediately related to surgery. If it has been separately agreed on and entered in the policy that expenses incurred abroad will also be reimbursed, the number of daily hospital charges specified in the insurance policy will be reimbursed.
- costs of an orthopaedic brace if it was the first orthopaedic brace acquired after a coverable operation. These expenses are only covered up to EUR 500 per operation.
- fees for MRI and CT scans
- fees for endoscopy
- fees for up to ten doctors' consultations during the insurance period related to a surgical procedure, MRI or CT scan or endoscopic examination
- costs for pharmaceutical products and wound dressings sold in pharmacies.

Expenses are not reimbursed if they are caused by

- orthotic insoles or other insoles, or other equipment or instruments
- an orthopaedic brace, unless it was the first orthopaedic brace acquired after a coverable operation. In cases like this, too, these expenses are only covered up to EUR 500 per operation.
- medical equipment or artificial limb (but the rental costs of forearm or underarm crutches are reimbursed if needed after a coverable surgical operation)
- refractive error operation
- purchase of micronutrients, minerals or vitamin preparations, unless they are considered pharmaceutical products
- purchase of nutritional products including clinical nutritional products
- basic creams or lotions or equivalent, unless they are used for treating an accidental injury
- purchase of anthroposophic or homeopathic products
- treatment whose primary reason is to improve the person's quality of life; this includes medication that enhances sexual performance. This restriction is not applied, however, in the case of pharmaceutical products that have been compensated under the Health Insurance Act.
- daily hospital charges unless they are immediately related to a coverable operation.

In addition to the above, restrictions in section 3.4 also apply.

3.4 Expenses which are not covered

This clause applies to both Cost Cover costs, i.e. medical and examination fees, and surgery / special examination fees.

Expenses are not reimbursed if they are caused by

- expenses arising from the examination or treatment provided by a physiotherapist, foot therapist, chiropractor, osteopath, naprapathy practitioner, masseur or equivalent healthcare professional
- acupuncture or lymphatic therapy
- examination or treatment by a nutritional therapist or equivalent healthcare professional
- examination or treatment by an occupational or speech therapist, psychologist, neuropsychologist or other equivalent healthcare professional
- psychotherapy or equivalent examination or treatment
- examination or treatment by an optician or equivalent healthcare professional
- examination or treatment by a dentist, specialised dentist, dental hygienist or dental technician
- pregnancy, childbirth, termination of pregnancy or examination or treatment of infertility or from complications caused by these events or conditions
- cataract operation

- examination or treatment related to outward appearance or looks
- examinations or treatments related to breast reduction, enlargement or modification, skin peeling or dermabrasion or the lifting or rejuvenation of eyelids, areas around the eyes or other facial feature
- medicinal treatment of obesity, liposuction, gastric bypass or sleeve operation or other weight-loss surgery or other obesity examination and treatment
- expenses arising from the examination or treatment of transsexuality
- varicose vein removal or other varicose vein treatment
- treatment primarily meant to enhance the quality of life
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction
- treatment for snoring, unless the treatment concerns sleep apnoea verified by means of sleep registration
- mole removal
- examination made or treatment given in the insured person's home, other house call and other than a practice or clinic
- spending time or staying at a place providing rehabilitation services or any actual services used
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

3.5 Filing a claim

3.5.1 Notification of illness or accident

The claimant shall submit to the insurance company a written clarification of any illnesses, accidents, examinations, treatments and aids. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

Fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

3.5.2 Receipts

The claimant must pay medical treatment expenses personally before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

3.6 Other applicable terms and conditions

The common provisions for personal insurance are applied.

4 Supplementary Medical Treatment Cover

4.1 Key contents of insurance cover

The following types of cover may be selected

- Musculoskeletal therapy expenses
- Functional therapy expenses
- Psychotherapy expenses
- Expenses for home health care
- Home help expenses
- Special expenses
- Expenses for home adaptations
- Expenses for end-of-life care.

The insurance policy shows which of the above have been chosen.

Each of the above cost covers can be chosen in the case of

A accidents and illnesses

This option compensates expenses to the insured person caused by accident or illness as specified in these terms and conditions.

B accidents and the following illnesses

- strain or rupture of a tendon, tendinitis or degeneration of tendon
- muscle strain or rupture
- herniation of intervertebral disk
- abdominal, umbilical or groin hernia
- rupture of meniscus in the knee, and
- dislocation of joint or kneecap.

This option compensates expenses to the insured person caused by accident or illness listed above as specified in these terms and conditions.

C accidents

This option compensates expenses to the insured person only caused by an accident as specified in these terms and conditions.

The insurance policy indicates which of the three options above has been chosen for each cost.

Compensation is only payable if the expenses are incurred while the policy is in force. If the expenses are caused by an accident, the accident must also have occurred during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

Each selected expense item has a maximum amount of indemnity entered in the insurance policy, which will not be exceeded during the validity of the insurance cover. Any compensation paid will reduce the remaining amount of indemnity that may be paid. Once the maximum compensation has been reached, coverage ends.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for. The above does not apply to home help expenses: its deductibles are detailed under its own heading.

Compensation is only paid for examination carried out or treatment provided in Finland or for a service provided or acquisition made in Finland.

If it has been separately agreed and the appropriate entry has been made in the policy concerning a certain type of expense, such expenses are covered even if they have incurred abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

4.2 Coverable and non-coverable expenses

4.2.1 Musculoskeletal therapy expenses

The condition for compensation to be paid is that the expenses for musculoskeletal therapy are included for the particular illness or injury. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of such expenses, we compensate examinations and treatments provided by a physiotherapist, foot therapist, osteopath, chiropractor or a naprapathy practitioner approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira).

The insurance policy indicates the maximum number of examinations and treatments per insurance period are compensated. Any examinations or treatment sessions exceeding the maximum over a single insurance period will not be compensated.

Expenses are not reimbursed if they are caused by

- medical equipment or other aids, treatment device, orthotic insole or other insole
- purchase of supports or bandages
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.2 Functional therapy expenses

The condition for compensation to be paid is that the expenses for functional therapy are included for the particular illness or injury. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of such expenses, we compensate examinations and treatments provided by a functional or speech therapist or neuropsychologist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira).

The insurance policy indicates the maximum number of examinations and treatments per insurance period are compensated. Any examinations or treatment sessions exceeding the maximum over a single insurance period will not be compensated.

Expenses are not reimbursed if they are caused by

- medical equipment or other aids, treatment device, orthotic insole or other insole
- purchase of supports or bandages
- child's speech development concerning the forming of a letter or letters and their pronunciation
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.3 Psychotherapy expenses

Psychotherapy expenses are covered in cases where an illness or bodily injury has also resulted in mental symptoms. What is more, the examination and treatment must have been prescribed by a physician. The examination or

treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the mental symptoms resulting from a coverable illness or bodily injury.

Of these expenses, the fees for psychotherapy provided by a psychotherapist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira) and fees for examinations or treatment provided by a psychologist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira) are covered.

If psychotherapy is provided in the form of couple, family or group therapy, only the insured person's share of the therapy is covered. Also in the case of examinations or treatment provided by a psychologist, only the insured person's share of the therapy is covered. The insurance policy indicates the maximum number of psychotherapy sessions and visits to a psychologist for examination and treatment that are compensated per insurance period. Any psychotherapy sessions or psychologist's examinations or treatments exceeding the maximum during the insurance period will not be compensated.

Expenses are not covered if they are caused by the abuse of medicine or the use of alcohol or other intoxicants. Nor are expenses covered if they were caused by the treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.4 Expenses for home health care

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home health care. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question. Examinations must be made and treatment provided by a professional employed by a local service provider.

Of these expenses, the following expenses are coverable

- examinations carried out and treatments provided by a medical doctor or nurse in the insured person's home or other place
- one phone consultation with a physician following a home call
- first-aid medication provided by a physician in examinations or treatments described above.

Expenses are not reimbursed if they are caused by

- examination or treatment other than in the insured person's home, such as a clinic or hospital
- pharmaceutical product or other product bought at a pharmacy
- acupuncture or lymphatic therapy
- psychotherapy or equivalent examination or treatment
- examination or treatment by a dentist or specialised dentist
- pregnancy, childbirth, termination of pregnancy or examination or treatment of infertility or from complications caused by these events or conditions
- examination or treatment related to outward appearance or looks
- examinations or treatments related to breast reduction, enlargement or modification, skin peeling or dermabrasion or the lifting or rejuvenation of eyelids, areas around the eyes or other facial feature
- obesity examination or treatment
- treatment primarily meant to enhance the quality of life
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction
- spending time or staying at a place providing rehabilitation services or any actual services used
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.5 Home help expenses

4.2.5.1 General information

Compensation is paid for carer and home cleaning expenses as specified in these terms and conditions.

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home help expenses.

The insurance policy indicates to what extent carer expenses are reimbursed per insurance event. The same information is included on home cleaning expenses. Expenses are never reimbursed in excess of the maximum compensation set for home help expenses.

A qualifying period has been specified for each insurance event. This qualifying period does not apply to home cleaning expenses. In the case of child care services, each continuous home care period has a qualifying period which begins on the first day when the insured person was in home care under doctor's orders. As to the services of a personal carer, the qualifying period begins on the first day when the insured person is in home care following surgery, and cannot manage alone at home without help.

4.2.5.2 Carer expenses

Compensation is paid either for child care or personal carer services.

4.2.5.2.1 Child care services

We cover expenses for child care services obtained through a service provider as a result of a child who is normally in daycare outside the home being required under doctor's orders to be looked after at home, due to illness or injury.

Expenses are covered up to the hours that the child would have been in daycare outside the home had it not been for the coverable illness or injury, but never for more than 10 hours per day.

If a carer is looking after more than one child at the same time, the insured child's share is compensated.

Expenses are not covered if

- the service provider does not have a business ID issued by the authorities
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.5.2.2 Services of a personal carer

We cover expenses for the services of a personal carer obtained through a service provider because the insured person who is of school age or older has had an operation for a coverable illness or injury and cannot manage on his/her own at home without help.

The expenses of a personal carer are covered to the extent that the carer has helped the insured person after being discharged from hospital in necessary daily activities.

Expenses are covered for up to three months per insurance event and for no more than 10 hours per day.

Expenses are not covered if the expense or service need is caused by

- pregnancy, childbirth, termination of pregnancy or examination or treatment of infertility or from complications caused by these events or conditions
- treatment related to outward appearance or looks
- treatments related to breast reduction, enlargement or modification, skin peeling or dermabrasion or the lifting or rejuvenation of eyelids, areas around the eyes or other facial feature
- liposuction, gastric bypass or sleeve operation or other weight-loss surgery or other obesity treatment
- varicose vein removal or other varicose vein treatment
- treatment primarily meant to enhance the quality of life
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction
- spending time or staying at a place providing rehabilitation services or any actual services used
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Moreover, expenses are not covered if

- the service provider does not have a business ID issued by the authorities
- the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.5.3 Home cleaning expenses

We cover expenses for the cleaning of an adult insured person's home by a service provider if the insured has been on continuous sick leave on doctor's orders for at least a fortnight. Expenses are covered for up to four hours of cleaning for each new week of illness.

Compensation for cleaning expenses is not paid if the expense or need for the service is the result of:

- pregnancy, childbirth, termination of pregnancy or examination or treatment of infertility or from complications caused by these events or conditions
- treatment related to outward appearance or looks
- treatments related to breast reduction, enlargement or modification, skin peeling or dermabrasion or the lifting or rejuvenation of eyelids, areas around the eyes or other facial feature
- liposuction, gastric bypass or sleeve operation or other weight-loss surgery or other obesity treatment
- varicose vein removal or other varicose vein treatment
- treatment primarily meant to enhance the quality of life
- abuse of medicine or the use of alcohol or other intoxicants
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Moreover, expenses are not covered if

- the service provider does not have a business ID issued by the authorities
- the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.6 Special expenses

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under special expenses. What is more, the illness or injury examination or treatment must have been prescribed by a physician and provided by a health care professional. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- expenses for procedures to treat cosmetic skin defects that are the result of a coverable illness or accident
- expenses for procedures to remove symptomatic moles

- expenses for the reconstruction of a body part lost due to a coverable illness or accident
- expenses for breast reduction operation if the operation was performed because their size caused physical symptoms of illness
- expenses for the removal of varicose veins or other treatment related to varicose veins when they have caused pigment changes to the skin, lesions or daily swelling, despite treatment with compression socks or stockings
- the above coverable procedures include any daily hospital charges. If it has been separately agreed on and entered in the policy that expenses incurred abroad will also be reimbursed, the number of daily hospital charges specified in the insurance policy will be reimbursed.
- expenses for examination or treatment carried out by a nutritional therapist. Up to five examinations and treatments provided by a nutritional therapist are compensated during an insurance period. If the insured has more such examinations or treatments during an insurance period, any examinations or treatments exceeding the above-mentioned maximum will not be compensated.
- expenses for the rental of auxiliary devices, treatment devices, furniture and equipment
- expenses for medicinal aids, treatment devices and exercise equipment. The above medicinal aids and devices are compensated up to EUR 200 per insurance period.
- expenses for clinical nutritional products sold at a pharmacy that were prescribed by a physician, provided these are coverable as medical expenses under the Health Insurance Act for the treatment of a coverable illness or injury. Following the deduction of the sum that was already compensated under the Health Insurance Act, we compensate half of the sum left for the insured to pay.

Coverable expenses do not include

- expenses for examinations or treatments performed by doctor or other healthcare professional before a coverable procedure
- expenses for examinations or treatments performed by doctor or other healthcare professional following a coverable procedure or hospital treatment immediately after a coverable procedure
- expenses for pharmaceutical products and wound dressings sold at pharmacies
- expenses for orthopaedic brace or bandage
- hygiene products, such as nappies and sanitary towels
- expenses for dental prosthetics, dental crowns or orthodontic treatment
- expenses for spectacles, sunglasses or contact lenses
- rental costs for forearm or underarm crutches, unless the need for them is caused by a procedure coverable from special expenses
- expenses for services of a unit providing social welfare or residential services, even though they may also include healthcare services.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not covered if they are caused by the abuse of medicine or the use of alcohol or other intoxicants. Nor are expenses covered if they were caused by the treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

4.2.7 Expenses for home adaptations

4.2.7.1 General

Expenses are reimbursed according to these conditions if the insured receives a permanent or temporary disability as a result of a coverable illness or injury.

Permanent functional disability refers to a medically assessed general handicap which the insured has incurred through illness or injury and which, according to medical prognosis, is unlikely to be healed. A permanent functional disability must also have continued for at least three months, before any assessment for home adaptation will be entered upon.

By temporary functional disability we refer to what is medically assessed as a temporary disability caused by a coverable illness or injury that prevents the insured from managing daily activities on their own.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act, Services and Assistance for the Disabled Act, Social Welfare Act or other legislation.

4.2.7.2 Home adaptation and home fixtures

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home adaptation expenses. A further requirement is that the home adaptations and acquisition of home fixtures are the result of this illness or injury and prescribed by a physician. Home adaptations and the acquisition of home fixtures must be necessary for the insured person to manage normal daily activities independently and to live at home.

Of these expenses, the following expenses are coverable

- widening of doorways, expenses for the removal of thresholds and any other obstacles in the home, and expenses for support handles installed in the home
- building of disabled ramps and bannisters in other than blocks of flats
- bathroom and lavatory adaptations
- lighting changes
- change of surface materials at home because of serious allergy

- adaptations to fixtures and fixed building and interior decoration materials
- any necessary lifting or alarm equipment and other fixtures, including the installation
- evaluation, design, any building permissions and supervision for the above adaptations.

Home adaptations and home fixture expenses are reimbursed

- only for one flat on the basis of all the illnesses and injuries the insured person is suffering from when the level of permanent disability is being evaluated. Compensation will no longer be paid on the basis of the above illnesses and injuries for the same flat once two years has elapsed since a physician ordered the adaptations to be made and the fixtures to be acquired. Compensation will not be paid for other flats on the basis of the above illnesses and injuries
- only for one flat and for up to EUR 2,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of temporary disability is being evaluated. Compensation will no longer be paid on the basis of the above illnesses and injuries for the same flat once two years has elapsed since a physician ordered the adaptations to be made and the fixtures to be acquired. Compensation will not be paid for other flats on the basis of the above illnesses and injuries.

If the insured has another illness or injury later, any compensation will be paid for new adaptations as specified above.

If the insured moves into a new home, home adaptations or the acquisition or installation are not compensated that were already compensated in the previous home, even if this need arose from a new illness or injury.

Home adaptations and the acquisition and installation of fixtures are compensated in terms of construction and building materials to the same level as the home otherwise is.

The insured is responsible for ordering the home adaptations and fixtures and construction and installation supervision.

Coverable expenses do not include

- situations in which, on the basis of the Services and Assistance for the Disabled Act, the insured has been diagnosed as requiring continuous institutional care
- renovation, adaptations or extension of a flat or house that increase the floor area
- holiday home adaptation that enhance its quality or constructions
- any adaptation outside the home except for disabled ramps and bannisters in other than blocks of flats
- any home adaptations or installation of home fixtures in any other than the insured person's home or holiday home
- any expenses caused by correction of a design, foundation, installation and construction error and damage caused by such an error
- anything caused by mould allergy
- any expenses caused by the abuse of medicine or the use of alcohol or other intoxicants
- any expenses caused by the treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction
- cases in which any right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- cases in which the same expense has already been reimbursed or if compensation has been sought under some other voluntary cover or insurance policy.

The insured person's travel or accommodation costs are not reimbursed.

It must be a professional working for a service provider operating near the insured person's home who carries out any home adaptations and installation of fixtures.

If a home is bought only after the injury, no such expenses are reimbursed which should already have been taken into consideration when selecting a home or in building a new one in the light of existing personal limitations.

4.2.7.3 Devices required for daily life, home appliances, equipment and safety aids

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home adaptation expenses. A further requirement is that the acquisition of auxiliary devices, home appliances, equipment and safety aids is the result of this illness or injury and prescribed by a physician. The auxiliary devices, home appliances, equipment and safety aids must be necessary in order that the insured may move about independently, communicate with others, or manage some other activity in his/her work or leisure time.

Of these expenses, the following expenses are coverable

- auxiliary devices, home appliances and equipment
- instruments that increase your personal safety and safe living.

Expenses for auxiliary devices, home appliances and equipment are compensated

- in the case of permanent disability for up to EUR 10,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of permanent disability is being evaluated
- in the case of temporary disability for up to EUR 1,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of temporary disability is being evaluated.

Expenses for devices that increase the insured person's personal safety and safe living are reimbursed

- in the case of permanent disability for up to EUR 3,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of permanent disability is being evaluated

- in the case of temporary disability for up to EUR 500 on the basis of all the illnesses and injuries the insured person is suffering from when the level of temporary disability is being evaluated.

If the insured has another illness or injury later, any compensation will be paid for auxiliary devices required for daily life, home appliances, equipment and safety aids as specified above.

The insured person is responsible for the ordering and installation supervision of auxiliary devices required for daily life, home appliances, equipment and safety aids.

Coverable expenses do not include

- expenses caused by the purchase of orthopaedic braces
- situations in which, on the basis of the Services and Assistance for the Disabled Act, the insured has been diagnosed as requiring continuous institutional care
- cases in which any right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- cases in which the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy
- expenses caused by the purchase of hygiene products, such as nappies or sanitary towels
- expenses caused by the purchase of dental prosthetics or dental crowns or orthodontic treatment
- expenses caused by the purchase of spectacles, sunglasses or contact lenses
- expenses caused by the abuse of medicine or the use of alcohol or other intoxicants
- expenses caused by the treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Expenses are not reimbursed if they are caused by

- motor vehicle or motor vehicle part purchase or motor vehicle alteration or improvement
- software in computer data media.

The insured person's travel or accommodation costs are not reimbursed.

It must be a professional working for a service provider operating near the insured person's home who instals the devices required for daily life, home appliances, equipment and safety aids.

4.2.8 Expenses for end-of-life care

The requirement for compensation is that a doctor has made an end-of-life care decision. A further condition is that it concerns an illness or injury that is coverable under end-of-life care. The examination or treatment procedures must be prescribed by a physician and in accordance with generally accepted medical practice, and necessary in terms of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- daily hospital charge for the duration of end-of-life care. If it has been separately agreed on and entered in the policy that expenses incurred abroad will also be reimbursed, the number of daily hospital charges specified in the insurance policy will be reimbursed.
- expenses for home health care examinations or treatment by a doctor or healthcare professional during end-of-life care
- expenses for supplies needed during end-of-life care in home health care, and pharmaceutical products, basic creams and clinical nutritional products sold at a pharmacy
- expenses for the rental of auxiliary devices, equipment and appliances needed for end-of-life care at home.

We also compensate expenses for the services of a personal carer obtained through a service provider when the need for such a carer is caused by the fact that the insured person cannot according to the doctor manage during end-of-life care with personal daily activities without help.

Expenses are not covered if

- they are caused by services of a unit providing social welfare or residential services, even though they may also include healthcare services
- the service provider does not have a business ID issued by the authorities
- they are caused by the abuse of medicine or the use of alcohol or other intoxicants
- the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

Indirect expenses, such as the insured person's travel, accommodation or meal expenses are not reimbursed.

4.3 Filing a claim

4.3.1 Notification of illness or accident

The claimant shall submit to the insurance company a written clarification of any illnesses, accidents, examinations, treatments and aids. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

4.3.2 Documentation on services and service providers

The claimant must send written documentation on the carer services related to end-of-life care, and child, carer and cleaning services included in home help expenses to the insurance company. You must also send documentation on the service providers by filling in the insurance company's loss report accompanied by any other relevant receipts.

4.3.3 Documentation on home adaptation reasons and expenses

The claimant must submit written documentation of a permanent or temporary disability, home adaptation, the home's fixtures and any aids, home appliances, equipment and safety aids needed for daily activities to the insurance company. This must be done in a manner separately approved by the insurance company.

4.3.4 Loss investigation costs

Claimants must acquire said documentation and information and medical statements and submit them to the insurance company at their own expense, unless otherwise specified in the terms and conditions concerning Supplementary Medical Treatment Expenses Cover.

4.3.5 Medical treatment expense receipts

The claimant must pay medical treatment expenses personally before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

4.3.6 Receipts for expenses concerning home adaptations

Claimants must first pay for any expenses concerning home adaptations and subsequently claim compensation pursuant to the Services and Assistance for the Disabled Act, either from the municipality or other party responsible for the expenses. Claimants must, upon request, submit to the insurance company either the municipality's or other responsible party's decision or other documentation of the compensation it has paid. Originals of the receipts for expenses which have not been reimbursed under the Services and Assistance for the Disabled Act or some other legislation must also be submitted upon request to the insurance company.

4.3.7 Compensation receipts of the services

Claimants must first pay any end-of-life carer expenses, and child care, carer and cleaning expenses that fall under home help. Claimants must, upon request, send the insurance company the original receipts.

4.4 Other applicable terms and conditions

The common provisions for personal insurance are applied to Supplementary Medical Treatment Cover.

5 Dental Cover

5.1 Key contents of insurance cover

Insurance can be taken out against

A accidents and illnesses

This option compensates expenses to the insured person caused by illness or accident as specified in these terms and conditions.

B against accidents

This option compensates expenses to the insured person caused by an accident as specified in these terms and conditions.

It has been entered in the insurance policy which option has been chosen.

Compensation is only payable if the expenses are incurred while the policy is in force. If the expenses are caused by an accident, the accident must also have occurred during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

During the validity of the insurance cover, expenses are covered up to a maximum compensation indicated in the insurance policy. The maximum compensation is subtracted with all compensation paid from the insurance. Insurance coverage ends when the maximum amount of compensation has been paid.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for.

Compensation is only paid for examination carried out or treatment provided in Finland or for an acquisition made in Finland. If it has been separately agreed and the appropriate entry has been made in the policy, such examinations, treatments or acquisitions may also be covered abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

5.2 Coverable expenses

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under Dental Cover. What is more, the illness or injury examination or treatment must have been prescribed by a dentist. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

In the case of accident

- expenses for examinations and treatment by a dentist, specialised dentist, dental hygienist or dental technician
- expenses for a fixed dental prosthetic or dentures made by a dentist or dental technician, or removable dental prosthetics or implant-supported dental prostheses
- costs for pharmaceutical products sold at pharmacies

in the case of illness

- examinations and treatment concerning the first dental prosthetic for a missing tooth

- expenses for a fixed dental prosthetic or dentures made by a dentist or dental technician, or removable dental prosthetics or implant-supported dental prostheses when they concern the first dental prosthetic for a missing tooth
- expenses for pharmaceutical products sold at a pharmacy, when the medicine is related to prosthetic treatment.

5.3 Expenses which are not covered

Expenses are not reimbursed if they are caused by

- preventative care
- filling a cavity or root canal treatment, unless related to an accident
- orthodontic treatment or mouthguard
- dental crown, unless in cases of accident
- dental prosthetic renewal, unless in cases of accident
- physiotherapy
- examination or treatment of jawbone or jaw joints, unless in the case of an accident
- dental check-up, local anaesthetic or medicinal product if they are not related to treatment that is otherwise covered
- tartar removal
- cosmetic dental treatment
- tooth extraction, unless prosthetic treatment is also included, or in cases of accident.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not covered if they are caused by the abuse of medicine or the use of alcohol or other intoxicants. Nor are expenses covered if they were caused by the treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

Injury caused by biting to a tooth or dentures is not coverable, even if an external factor has contributed to the damage.

5.4 Filing a claim

5.4.1 Notification of illness or accident

The claimant shall submit to the insurance company a written clarification of any illnesses, accidents, examinations and treatments. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

The fee for a doctor's statement is reimbursed only if the insurance company has specifically requested for one. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

5.4.2 Receipts

The claimant must pay medical treatment expenses personally before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

5.5 Other applicable terms and conditions

The common provisions for personal insurance are applied.

6 Fitness Cover

6.1 Key contents of insurance cover

Coverage may be chosen against expenses caused by the following services

- fitness tests and expert services
- fitness tests.

It has been entered in the insurance policy which option has been chosen.

Compensation will not be paid unless a doctor or some other health care professional recommends the insured to do exercise as treatment for an illness, injury or factor that threatens the insured person's health.

Compensation is only payable if the expenses are incurred while the policy is in force.

During the validity of the insurance cover, expenses are covered up to the amount indicated in the insurance policy. The maximum compensation is subtracted with all compensation paid from the insurance. Insurance coverage ends when the maximum amount of compensation has been paid.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for.

6.2 Fitness tests and expert services

6.2.1 Fitness tests

Compensation is paid for fitness tests supervised by a service provider, taking the form of a bicycle ergometer test.

Only the expenses of one fitness test per insurance period will be reimbursed. Only up to three fitness tests will be compensated on the basis of all the illnesses, injuries or factors that threaten the insured person's health that the insured had at the time when exercise was recommended.

6.2.2 Expert services

If fitness test expenses are coverable, we compensate expenses per each coverable fitness test that are the result of

1. a basic medical check-up by a GP and any laboratory tests s/he may prescribe, but totalling no more than EUR 160, or
2. the services of a nutritional therapist, but only up to EUR 160, or
3. personal, individual gym or exercise guidance, but only up to EUR 160.

Expenses are covered per each coverable fitness test only under item 1, 2 or 3. If, during a single insurance period, the insured uses services under more than one of the items above, compensation is only paid under one of them.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act.

Compensation is only paid for expert services provided in Finland.

6.3 Fitness tests

Compensation is paid for fitness tests supervised by a service provider, taking the form of a bicycle ergometer test.

Only the expenses of one fitness test per insurance period will be reimbursed. Only up to three fitness tests will be compensated on the basis of all the illnesses, injuries or factors that threaten the insured person's health that the insured had at the time when exercise was recommended.

6.4 Exclusions

No compensation is paid if an illness, injury or factor threatening the insured person's health is the result of abuse of medicine or the use of alcohol or other intoxicants. Nor are expenses covered if they were caused by the treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

6.5 Filing a claim

6.5.1 Documentation on fitness tests and expert services

Claimants must submit to the insurance company written documentation indicating that a doctor or other health care professional has recommended exercise to the insured as treatment for an illness, injury or factor threatening his/her health. This must be done in a manner separately approved by the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

Fees charged by doctors or other health care professionals for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

6.5.2 Receipts

Claimants must first pay the expenses for fitness tests and expert services. Claimants must, upon request, send the insurance company the original receipts.

6.6 Other applicable terms and conditions

The common provisions for personal insurance are applied.

7 Athletes' Medical Treatment Cover

7.1 Key contents of insurance cover

Athletes' Medical Treatment Cover is valid in those competitive sports and high-risk sports that have been entered in the insurance policy. Athletes' Medical Treatment Cover is valid in special sports if so indicated in the insurance policy. Clause 3.2 (Validity in sports) in the general conditions of the common provisions of personal insurance specifies in more detail about the validity of Athletes' Medical Treatment Cover in sports.

Insurance can be taken out against

A Accidents and the following illnesses

- abdominal, umbilical or groin hernia
- rupture of meniscus in the knee
- dislocation of joint or kneecap
- shin splints, or medial tibial stress syndrome
- stress fracture or its initial stage
- tennis elbow, or lateral epicondylitis
- golfer's elbow, or medial epicondylitis
- inflammation or rupture of Achilles tendon
- inflammation of shoulder tendons
- bursitis
- plantar fasciitis.

This option compensates expenses to the insured person caused by accident or exertion that occurred when performing a sport entered in the insurance policy or illness when performing a sport listed in the insurance policy.

B against accidents

This option compensates expenses to the insured person caused by accident or exertion that occurred when performing a sport entered in the insurance policy.

The insurance policy indicates which option above has been chosen.

Compensation is only payable if the expenses are incurred while the policy is in force. If the expenses are caused by an accident, the accident must also have occurred when performing a sport entered in the insurance policy during the validity of the insurance. If the expenses are caused by an exertion, the exertion must also have occurred when performing a sport entered in the insurance policy during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

During the validity of the insurance cover, expenses are covered up to a maximum compensation indicated in the insurance policy. The maximum compensation is subtracted with all compensation paid from the insurance. Insurance coverage ends when the maximum amount of compensation has been paid.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for.

Compensation is only paid for examination carried out or treatment provided in Finland or for an acquisition made in Finland. If it has been separately agreed and the appropriate entry has been made in the policy, such examinations, treatments or acquisitions may also be covered abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

7.2 Coverable expenses

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under Athletes' Medical Treatment Cover. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- fees for examination and treatment procedures carried out by physicians and healthcare professionals at their practice or clinic
- costs of pharmaceutical products and wound dressings sold at pharmacies
- daily hospital charges. If it has been separately agreed on and entered in the policy that expenses incurred abroad will also be reimbursed, the number of daily hospital charges specified in the insurance policy will be reimbursed.
- costs of an orthopaedic brace if it was the first orthopaedic brace acquired after a coverable operation or accident. These expenses are only covered up to EUR 500 per operation or accident
- rental costs of forearm or underarm crutches.

7.3 Expenses which are not covered

Expenses are not reimbursed if they are caused by

- expenses arising from the examination or treatment provided by a physiotherapist, foot therapist, chiropractor, osteopath, naprapathy practitioner, masseur or equivalent healthcare professional
- acupuncture or lymphatic therapy
- examination or treatment by a nutritional therapist or equivalent healthcare professional
- examination or treatment by an occupational or speech therapist, psychologist, neuropsychologist or other equivalent healthcare professional
- examination or treatment by a dentist, specialised dentist, dental hygienist or dental technician
- drug abuse
- purchase of micronutrients, minerals or vitamin preparations, unless they are considered pharmaceutical products
- purchase of nutritional products including clinical nutritional products
- basic creams or lotions or equivalent, unless they are used for treating an accidental injury
- purchase of anthroposophic or homeopathic products
- examination or treatment related to outward appearance or looks
- reconstruction of a lost body part
- medical equipment or other aids, orthotic insole or other insole or artificial limb (however, the rental costs of forearm or underarm crutches are reimbursed)
- costs of an orthopaedic brace unless it was the first orthopaedic brace acquired after a coverable operation or accident. In cases like this, too, these expenses are only covered up to EUR 500 per operation or accident.
- examination made or treatment given in the insured person's home, other house call and other than a practice or clinic
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

7.4 Filing a claim

7.4.1 Notification of illness, accident or exertion

The claimant shall submit a written clarification of any illnesses, accidents, exertions, examinations, treatments and auxiliary devices to the insurance company . This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

Fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

7.4.2 Receipts

The claimant must pay the medical treatment expenses him/herself before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claim-

ant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

7.5 Other applicable terms and conditions

The common provisions for personal insurance are applied.

8 Athletes' Supplementary Medical Treatment Cover

8.1 Key contents of insurance cover

Athletes' Supplementary Medical Treatment Cover is valid in those competitive sports and high-risk sports that have been entered in the insurance policy. Athletes' Supplementary Medical Treatment Cover is valid is special sports if so indicated in the insurance policy. Clause 3.2 (Validity in sports) in the general conditions of the common provisions of personal insurance specifies in more detail about the validity of Athletes' Supplementary Medical Treatment Cover in sports.

The following types of cover may be selected

- Musculoskeletal therapy expenses
- Functional therapy expenses
- Expenses for home health care
- Home help expenses
- Special expenses
- Expenses for home adaptations.

The insurance policy shows which of the above have been chosen.

Each of the above cost covers can be chosen in the case of

A Accidents and the following illnesses

- abdominal, umbilical or groin hernia
- rupture of meniscus in the knee
- dislocation of joint or kneecap
- shin splints, or medial tibial stress syndrome
- stress fracture or its initial stage
- tennis elbow, or lateral epicondylitis
- golfer's elbow, or medial epicondylitis
- inflammation or rupture of Achilles tendon
- inflammation of shoulder tendons
- bursitis
- plantar fasciitis.

  This option compensates expenses to the insured person caused by accident or exertion that occurred when performing a sport entered in the insurance policy or illness when performing a sport listed in the insurance policy.

B against accidents

  This option compensates expenses to the insured person caused by accident or exertion that occurred when performing a sport entered in the insurance policy.

The insurance policy indicates which of the options above has been chosen for each cost.

Compensation is only payable if the expenses are incurred while the policy is in force. If the expenses are caused by an accident, the accident must also have occurred when performing a sport entered in the insurance policy during the validity of the insurance. If the expenses are caused by an exertion, the exertion must also have occurred when performing a sport entered in the insurance policy during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

Each selected expense item has a maximum amount of indemnity entered in the insurance policy, which will not be exceeded during the validity of the insurance cover. Any compensation paid will reduce the remaining amount of indemnity that may be paid. Once the maximum compensation has been reached, coverage ends.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for. The above does not apply to home help expenses: its deductibles are detailed under its own heading.

Compensation is only paid for examination carried out or treatment provided in Finland or for a service provided or acquisition made in Finland.

If it has been separately agreed and the appropriate entry has been made in the policy concerning a certain type of expense, such expenses are covered even if they have incurred abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

8.2 Coverable and non-coverable expenses

8.2.1 Musculoskeletal therapy expenses

The condition for compensation to be paid is that the expenses for musculoskeletal therapy are included for the particular illness or injury. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of such expenses, we compensate examinations and treatments provided by a physiotherapist, foot therapist, osteopath, chiropractor or a naprapathy practitioner approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira).

The insurance policy indicates the maximum number of examinations and treatments per insurance period are compensated. Any examinations or treatment sessions exceeding the maximum over a single insurance period will not be compensated.

Expenses are not reimbursed if they are caused by

- medical equipment or other aids, treatment device, orthotic insole or other insole
- purchase of supports or bandages.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.2 Functional therapy expenses

The condition for compensation to be paid is that the expenses for functional therapy are included for the particular illness or injury. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of such expenses, we compensate examinations and treatments provided by a functional or speech therapist or neuropsychologist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira).

The insurance policy indicates the maximum number of examinations and treatments per insurance period are compensated. Any examinations or treatment sessions exceeding the maximum over a single insurance period will not be compensated.

Expenses are not reimbursed if they are caused by

- medical equipment or other aids, treatment device, orthotic insole or other insole
- purchase of supports or bandages.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.3 Expenses for home health care

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home health care. In addition, the illness or injury examination or treatment must have been prescribed by a physician. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question. Examinations must be made and treatment provided by a professional employed by a local service provider.

Of these expenses, the following expenses are coverable

- examinations carried out and treatments provided by a medical doctor or nurse in the insured person's home or other place
- one phone consultation with a physician following a home call
- first-aid medication provided by a physician in examinations or treatments described above.

Expenses are not reimbursed if they are caused by

- examination or treatment other than in the insured person's home, such as a clinic or hospital
- pharmaceutical product or other product bought at a pharmacy
- acupuncture or lymphatic therapy
- drug abuse
- examination or treatment related to outward appearance or looks
- examination or treatment by a dentist or specialised dentist
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.4 Home help expenses

8.2.4.1 General information

Compensation is paid for carer and home cleaning expenses as specified in these terms and conditions.

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home help expenses.

The insurance policy indicates to what extent carer expenses are reimbursed per insurance event. The same information is included on home cleaning expenses. Expenses are never reimbursed in excess of the maximum compensation set for home help expenses.

A qualifying period has been specified for each insurance event. This qualifying period does not apply to home cleaning expenses. In the case of child care services, each continuous home care period has a qualifying period which begins on the first day when the insured person was in home care under doctor's orders. As to the services of a personal carer, the qualifying period begins on the first day when the insured person is in home care following surgery, and cannot manage alone at home without help.

8.2.4.2 Carer expenses

Compensation is paid either for child care or personal carer services.

8.2.4.2.1 Child care services

We cover expenses for child care services obtained through a service provider as a result of a child who is normally in daycare outside the home being required under doctor's orders to be looked after at home, due to illness or injury.

Expenses are covered up to the hours that the child would have been in daycare outside the home had it not been for the coverable illness or injury, but never for more than 10 hours per day.

If a carer is looking after more than one child at the same time, the insured child's share is compensated.

Expenses are not covered if

- the service provider does not have a business ID issued by the authorities
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.4.2.2 Services of a personal carer

We cover expenses for the services of a personal carer obtained through a service provider because the insured person who is of school age or older has had an operation for a coverable illness or injury and cannot manage on his/her own at home without help.

The expenses of a personal carer are covered to the extent that the carer has helped the insured person after being discharged from hospital in necessary daily activities.

Expenses are covered for up to three months per insurance event and for no more than 10 hours per day.

Expenses are not covered if the expense or service need is caused by

- drug abuse
- treatment related to outward appearance or looks
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Moreover, expenses are not covered if

- the service provider does not have a business ID issued by the authorities
- the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.4.3 Home cleaning expenses

We cover expenses for the cleaning of an adult insured person's home by a service provider if the insured has been on continuous sick leave on doctor's orders for at least a fortnight. Expenses are covered for up to four hours of cleaning for each new week of illness.

Reimbursement for cleaning expenses is not paid if the expense or need for the service is the result of drug abuse.

Moreover, expenses are not covered if

- the service provider does not have a business ID issued by the authorities
- the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.5 Special expenses

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under special expenses. What is more, the illness or injury examination or treatment must have been prescribed by a physician and provided by a health care professional. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable illness or injury in question.

Of these expenses, the following are coverable:

- expenses for procedures to treat cosmetic skin defects that are the result of a coverable illness or accident
- expenses for the reconstruction of a body part lost due to a coverable illness or accident
- the above coverable procedures include any daily hospital charges. If it has been separately agreed on and entered in the policy that expenses incurred abroad will also be reimbursed, the number of daily hospital charges specified in the insurance policy will be reimbursed.
- expenses for an orthopaedic brace or bandage needed by the insured to perform a sport following a coverable illness or accident
- expenses for the rental of auxiliary devices, treatment equipment and furniture related to a coverable illness or accident
- Expenses for auxiliary devices, treatment devices and exercise equipment related to a coverable illness or accident. The above medicinal aids and devices are compensated up to EUR 200 per insurance period.

Coverable expenses do not include

- expenses for examinations or treatments performed by doctor or other healthcare professional before a coverable procedure
- expenses for examinations or treatments performed by doctor or other healthcare professional following a coverable procedure or hospital treatment immediately after a coverable procedure
- expenses for pharmaceutical products and wound dressings sold at pharmacies
- expenses for spectacles, sunglasses or contact lenses
- rental costs for forearm or underarm crutches, unless the need for them is caused by a procedure coverable from special expenses
- expenses for services of a unit providing social welfare or residential services, even though they may also include healthcare services.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

8.2.6 Expenses for home adaptations

8.2.6.1 General information

Expenses are reimbursed according to these conditions if the insured receives a permanent or temporary disability as a result of a coverable illness or injury.

Permanent functional disability refers to a medically assessed general handicap which the insured has incurred through illness or injury and which, according to medical prognosis, is unlikely to be healed. A permanent functional disability must also have continued for at least three months, before any assessment for home adaptation will be entered upon.

By temporary functional disability we refer to what is medically assessed as a temporary disability caused by a coverable illness or injury that prevents the insured from managing daily activities on their own.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act, Services and Assistance for the Disabled Act, Social Welfare Act or other legislation.

8.2.6.2 Home adaptation and home fixtures

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home adaptation expenses. A further requirement is that the home adaptations and acquisition of home fixtures are the result of this illness or injury and prescribed by a physician. Home adaptations and the acquisition of home fixtures must be necessary for the insured person to manage normal daily activities independently and to live at home.

Of these expenses, the following expenses are coverable

- widening of doorways, expenses for the removal of thresholds and any other obstacles in the home, and expenses for support handles installed in the home
- building of disabled ramps and bannisters in other than blocks of flats
- bathroom and lavatory adaptations
- lighting changes
- change of surface materials at home because of serious allergy
- adaptations to fixtures and fixed building and interior decoration materials
- any necessary lifting or alarm equipment and other fixtures, including the installation
- evaluation, design, any building permissions and supervision for the above adaptations.

Home adaptations and home fixture expenses are reimbursed

- only for one flat on the basis of all the illnesses and injuries the insured person is suffering from when the level of permanent disability is being evaluated. Compensation will no longer be paid on the basis of the above illnesses and injuries for the same flat once two years has elapsed since a physician ordered the adaptations to be made and the fixtures to be acquired. Compensation will not be paid for other flats on the basis of the above illnesses and injuries
- only for one flat and for up to EUR 2,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of temporary disability is being evaluated. Compensation will no longer be paid on the basis of the above illnesses and injuries for the same flat once two years has elapsed since a physician ordered the adaptations to be made and the fixtures to be acquired. Compensation will not be paid for other flats on the basis of the above illnesses and injuries.

If the insured has another illness or injury later, any compensation will be paid for new adaptations as specified above.

If the insured moves into a new home, home adaptations or the acquisition or installation are not compensated that were already compensated in the previous home, even if this need arose from a new illness or injury.

Home adaptations and the acquisition and installation of fixtures are compensated in terms of construction and building materials to the same level as the home otherwise is.

The insured is responsible for ordering the home adaptations and fixtures and construction and installation supervision.

Coverable expenses do not include

- situations in which, on the basis of the Services and Assistance for the Disabled Act, the insured has been diagnosed as requiring continuous institutional care
- renovation, adaptations or extension of a flat or house that increase the floor area
- holiday home adaptation that enhance its quality or constructions
- any adaptation outside the home except for disabled ramps and bannisters in other than blocks of flats
- any home adaptations or installation of home fixtures in any other than the insured person's home or holiday home
- any expenses caused by correction of a design, foundation, installation and construction error and damage caused by such an error
- anything caused by mould allergy
- cases in which any right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- cases in which the same expense has already been reimbursed or if compensation has been sought under some other voluntary cover or insurance policy.

The insured person's travel or accommodation costs are not reimbursed.

It must be a professional working for a service provider operating near the insured person's home who carries out any home adaptations and installation of fixtures.

If a home is bought only after the injury, no such expenses are reimbursed which should already have been taken into consideration when selecting a home or in building a new one in the light of existing personal limitations.

8.2.6.3 Devices required for daily life, home appliances, equipment and safety aids

The condition for compensation to be paid is that it concerns an illness or injury that is coverable under home adaptation expenses. A further requirement is that the acquisition of auxiliary devices, home appliances, equipment and safety aids is the result of this illness or injury and prescribed by a physician. The auxiliary devices, home appliances, equipment and safety aids must be necessary in order that the insured may move about independently, communicate with others, or manage some other activity in his/her work or leisure time.

Of these expenses, the following expenses are coverable

- auxiliary devices, home appliances and equipment
- instruments that increase your personal safety and safe living.

Expenses for auxiliary devices, home appliances and equipment are compensated

- in the case of permanent disability for up to EUR 10,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of permanent disability is being evaluated
- in the case of temporary disability for up to EUR 1,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of temporary disability is being evaluated.

Expenses for devices that increase the insured person's personal safety and safe living are reimbursed

- in the case of permanent disability for up to EUR 3,000 on the basis of all the illnesses and injuries the insured person is suffering from when the level of permanent disability is being evaluated
- in the case of temporary disability for up to EUR 500 on the basis of all the illnesses and injuries the insured person is suffering from when the level of temporary disability is being evaluated.

If the insured has another illness or injury later, any compensation will be paid for auxiliary devices required for daily life, home appliances, equipment and safety aids as specified above.

The insured person is responsible for the ordering and installation supervision of auxiliary devices required for daily life, home appliances, equipment and safety aids.

Coverable expenses do not include

- situations in which, on the basis of the Services and Assistance for the Disabled Act, the insured has been diagnosed as requiring continuous institutional care
- cases in which any right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility
- cases in which the same expense has already been reimbursed or if compensation has been sought under some other voluntary cover or insurance policy.

Expenses are not reimbursed if they are caused by

- motor vehicle or motor vehicle part purchase or motor vehicle alteration or improvement
- software in computer data media.

The insured person's travel or accommodation costs are not reimbursed.

It must be a professional working for a service provider operating near the insured person's home who instals the devices required for daily life, home appliances, equipment and safety aids.

8.3 Filing a claim

8.3.1 Notification of illness, accident or exertion

The claimant shall submit a written clarification of any illnesses, accidents, exertions, examinations, treatments and auxiliary devices to the insurance company . This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

8.3.2 Documentation on services and service providers

The claimant must send written documentation on child, carer and cleaning services included in home help expenses to the insurance company. You must also send documentation on the service providers by filling in the insurance company's loss report accompanied by any other relevant receipts.

8.3.3 Documentation on home adaptation reasons and expenses

The claimant must submit written documentation of a permanent or temporary disability, home adaptation, the home's fixtures and any aids, home appliances, equipment and safety aids needed for daily activities to the insurance company. This must be done in a manner separately approved by the insurance company.

8.3.4 Loss investigation costs

Claimants must acquire said documentation and information and medical statements and submit them to the insurance company at their own expense, unless otherwise specified in the terms and conditions concerning Supplementary Medical Treatment Cover.

8.3.5 Medical treatment expense receipts

The claimant must pay for the treatment expenses

before filing a claim. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months

of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

8.3.6 Receipts for expenses concerning home adaptations

Claimants must first pay for any expenses concerning home adaptations and subsequently claim compensation pursuant to the Services and Assistance for the Disabled Act, either from the municipality or other party responsible for the expenses. Claimants must, upon request, submit to the insurance company either the municipality's or other responsible party's decision or other documentation of the compensation it has paid. Originals of the receipts for expenses which have not been reimbursed under the Services and Assistance for the Disabled Act or some other legislation must also be submitted upon request to the insurance company.

8.3.7 Compensation receipts of the services

Claimants must first pay any child care, carer and cleaning expenses that fall under home help. Claimants must, upon request, send the insurance company the original receipts.

8.4 Other applicable terms and conditions

The common provisions for personal insurance are applied to Athletes' Supplementary Medical Treatment Cover.

9 Athletes' Dental Cover

9.1 Key contents of insurance cover

Athletes' Dental Cover is valid in those competitive sports and high-risk sports that have been entered in the insurance policy. Athletes' Dental Cover is valid is special sports if so indicated in the insurance policy. Clause 3.2 (Validity in sports) in the general conditions of the common provisions of personal insurance specifies in more detail about the validity of Athletes' Dental Cover in sports.

This insurance compensates expenses to the insured person caused by accident that occurred when performing a sport entered in the insurance policy.

Compensation will be paid only if the accident occurred and the expenses have incurred during the validity of the insurance.

Expenses are coverable as far as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or other legislation.

During the validity of the insurance cover, expenses are covered up to a maximum compensation indicated in the insurance policy. The maximum compensation is subtracted with all compensation paid from the insurance. Insurance coverage ends when the maximum amount of compensation has been paid.

The deductible stated in the insurance policy will be deducted from coverable expenses. The deductible is determined on the basis of the date on which compensation is claimed for.

Compensation is only paid for examination carried out or treatment provided in Finland or for an acquisition made in Finland. If it has been separately agreed and the appropriate entry has been made in the policy, such examinations, treatments or acquisitions may also be covered abroad. In cases like this, the Finnish healthcare professional referred to in the terms and conditions will be replaced by a corresponding healthcare professional of the country in question, approved by the country's equivalent to the Finnish National Supervisory Authority for Welfare and Health.

9.2 Coverable expenses

Expenses are covered provided that the examination and treatment of the injury is performed or prescribed by a dentist. The examination or treatment procedures must also be in accordance with generally accepted medical practice and necessary for the treatment of the coverable injury in question.

Of these expenses, the following expenses are coverable

- examinations and treatment by a dentist, specialised dentist, dental hygienist or dental technician
- pharmaceutical products sold at pharmacies
- fixed dental prosthetic or dentures made by a dentist or dental technician, or removable dental prosthetics or implant-supported dental prostheses.

9.3 Expenses which are not covered

Expenses are not reimbursed if they are caused by

- physiotherapy
- dental check-up, local anaesthetic or medicinal product if they are not related to treatment that is otherwise covered
- cosmetic dental treatment.

Indirect expenses, such as travel, accommodation or meal expenses are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

Injury caused by biting to a tooth or dentures is not coverable, even if an external factor has contributed to the damage.

9.4 Filing a claim

9.4.1 Notification of an accident

The claimant shall submit a written clarification of any accidents, examinations and treatments to the insurance company. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

The fee for a doctor's statement is reimbursed only if the insurance company has specifically requested for one. Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

9.4.2 Receipts

The claimant must pay medical treatment expenses personally before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must, upon request, provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

9.5 Other applicable terms and conditions

The common provisions for personal insurance are applied.

LIVING ALLOWANCE INSURANCE

1 Insurance coverage

The following types of coverage are available:

- Disability Cover
- Death Cover
- Daily Allowance Cover.

The types of cover for each insured person are stated in the policy document.

2 Disability Cover

2.1 Key contents of insurance cover

The right to compensation arises if the insured suffers permanent disability caused by an accident which occurred during the validity of the cover and the permanent disability has continued for three months, with the cover being valid throughout that time.

Permanent disability refers to a medically assessed general handicap which the insured has incurred through an injury and which, according to medical prognosis, is unlikely to be healed. In determining the handicap, only the nature of the injury is taken into account. The individual circumstances of the injured person, such as their profession or leisure-time pursuits, do not affect the determination of the handicap.

The degree of handicap is determined in accordance with the disability category decree issued by the Government on the basis of the Workers' Compensation Act and valid when the accident occurred. Injuries are divided into disability categories 1–20, with category 20 corresponding to full handicap and category 1 to the smallest coverable handicap.

The benefit for full, permanent handicap as per class 20 is paid as a lump sum equal to the sum entered in the insurance policy valid at the time the accident occurred. For partial, permanent handicap, the benefit is paid as a lump sum equal to as many twentieths of the sum as indicated by the handicap class.

A handicap is considered permanent once it has been medically diagnosed as such, and this can be done no sooner than three months and no later than three years after the accident. The cover must be valid at this time.

If the degree of handicap changes by at least two handicap classes before three years have elapsed since the accident, the amount of benefit must be revised correspondingly, provided the Disability Cover is still valid. However, no benefit already paid will be recovered.

The benefit will be paid under the insurance terms and conditions valid at the time of the accident.

2.1.1 Exclusions

No compensation is paid for the psychic consequences of an accident.

When the insured is a foetus, the right to compensation may only be realised in accordance with clause 2.2.

2.2 Key contents of insurance cover when the insured is a foetus

When the insured is a foetus, this clause applies until birth. A child is considered to have been born when s/he is outside the body of the mother and the umbilical cord has been severed.

The right to compensation arises if the insured suffers permanent handicap caused by a coverable event which occurred during the validity of the cover and the permanent handicap has continued for three months, with the cover being valid throughout that time.

When the insured is a foetus, coverable events consist of the following:

- the insured suffers permanent disability in a road accident involving a motor vehicle
- the insured suffers permanent disability during labour, with the birth taking place no earlier than the 32nd week of pregnancy. Childbirth is considered to be over for the child when s/he is outside the body of the mother and the umbilical cord has been severed.

Permanent disability refers to a medically assessed general handicap which the insured has incurred through an injury and which, according to medical prognosis, is unlikely to be healed. In determining the handicap, only the nature of the injury is taken into account.

The degree of handicap is determined in accordance with the handicap classification decree issued by the Government on the basis of the Workers' Compensation Act, and valid when the accident occurred. The benefit for a permanent handicap of at least class 1 is paid as a lump sum equal to the sum entered in the insurance policy valid at the time the coverable event occurred.

A handicap is considered permanent once it has been medically diagnosed as such, and this can be done between three and six month after birth. The cover must be valid at this time.

The benefit will be paid under the insurance terms and conditions valid at the time of the coverable event.

2.2.1 Exclusions

This insurance does not cover home births.

When the conditions in clause 2.2 concerning a foetus are fulfilled, the right to compensation does not exist as specified in clause 2.1, Key contents of insurance cover.

2.3 Filing a claim

The claimant must notify the insurance company of the accident in writing by filling in the insurance company's loss report, accompanied by any other relevant documentation.

In order for the disability benefit to be processed, the claimant must send, upon request, an E Doctor's statement to the insurance company, describing the handicap. The fee for a doctor's statement is reimbursed only if the insurance company has specifically requested for one.

2.4 Other applicable terms and conditions

The common provisions for personal insurance are applied.

3 Death Cover

3.1 Key contents of insurance cover

The right to compensation arises if the insured dies as a result of an accident which occurred during the validity of the cover.

The compensation is the sum entered in the insurance policy valid at the time of the accident.

The benefit will be paid under the insurance terms and conditions valid at the time of the accident.

3.1.1 Exclusions

The benefit will not be paid if the insured dies after three years have elapsed since the accident occurred.

When the insured is a foetus, the right to compensation may only be realised in accordance with clause 3.2.

3.2 Key contents of insurance cover when the insured is a foetus

The right to compensation arises if the insured dies as a result of a coverable event which occurred during the validity of the cover.

When the insured is a foetus, coverable events consist of the following:

- the insured foetus is stillborn as a result of a road accident involving a motor vehicle
- the child is stillborn in week 32 of the pregnancy or later, and if the reason for the death is an external factor
- the child dies owing to an external factor during labour taking place no earlier than the 32nd week of pregnancy. Childbirth is considered to be over for the child when s/he is outside the body of the mother and the umbilical cord has been severed. Right to compensation under this clause expires 24 hours from the end of childbirth.

The compensation is the sum entered in the insurance policy valid at the time of the coverable event.

The benefit will be paid under the insurance terms and conditions valid at the time of the coverable event.

3.2.1 Exclusions

This insurance does not cover home births.

When the conditions in clause 3.2 concerning a foetus are fulfilled, right to compensation does not exist as specified in clause 3.1, Key contents of insurance cover.

3.3 Filing a claim

The claimant must notify the insurance company of the accident in writing

For the processing of death benefit, the claimant must provide the insurance company with a death certificate for the insured and official extracts from the population register or equivalent, on beneficiaries. The insurance company must also be sent, upon request, further documentation by the authorities on the cause of death.

Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

3.4 Other applicable terms and conditions

The common provisions for personal insurance are applied.

4 Daily Allowance Cover

4.1 Key contents of insurance cover

The right to compensation arises if the insured who is in an employment relationship becomes unable to work as a result of an accident which occurred during the validity of the cover.

A daily reimbursement to the amount that was entered in the insurance policy on the date of the accident will be paid for the days when the insured is fully unable to do the work he has been employed to do; and when work disability is only partial, the amount corresponding to the amount of work disability will be paid. Compensation will only be paid for the days when the cover is valid.

The insured will be considered fully unable to work if, owing to an accident that occurred while the cover was valid, s/he is – judged on medical grounds – unable to perform any of his/her usual work duties. The insured will be considered partly unable to work if owing to an accident that occurred while the cover was valid, he is – judged on medical grounds – unable to perform some of his usual work duties.

The compensation is paid for as many days as the incapacity for work continues in excess off the qualifying period mentioned in the policy. The qualifying period will be subtracted once per each accident. The qualifying period begins on the first day of the incapacity for work as stated by a physician.

Benefit for any single accident is paid up to the maximum period stated in the policy.

The benefit will be paid under the insurance terms and conditions valid at the time of the accident.

The cover expires at the end of the insurance period during which the insured reaches 70 years of age.

4.2 Exclusions

Compensation will not be paid

- for psychological consequences of an accident
- if the insured is not in an employment relationship when the accident occurs.

4.3 Filing a claim

The claimant must notify the insurance company of the journey and accident in writing and any current work relationships by filling in the insurance company's loss report, accompanied by any other relevant documentation.

For the purposes of having the daily benefit application processed, the claimant must submit documentation to us showing the disability period and the reason for the disability. A tax card must also be sent to us for payment of the benefit.

Claimants must acquire said documentation and information and submit them to the insurance company at their own expense.

4.4 Other applicable terms and conditions

The common provisions for personal insurance are applied.

LIFE INSURANCE

1 Key contents of insurance cover

The right to benefits arises if the insured dies during the validity of the insurance.

The insurance may be taken out for single persons or for couples (joint cover).

The compensation is the amount of compensation in the insurance policy at the time of death.

In the case of joint cover, the benefit is paid only once, when either one of those insured dies. If those insured die simultaneously, each one's beneficiary is entitled to half the amount of compensation.

Single-person insurance cover expires at the end of the insurance period during which the insured reaches 70 years of age.

Joint cover expires if either one of those insured dies or at the end of the insurance period during which either one of those insured reaches 70 years of age. The insurance continues for the survivor or under 70-year-old insured as single cover with the same amount of compensation.

The insurance cover is Death Cover.

2 Exclusion

No benefit is paid if the insured has committed suicide within a period of one year from the beginning of the insurance.

3 Filing a claim

The claimant must submit a death certificate for the insured, official extracts from the population register or equivalent on beneficiaries and an address for payment of the benefit to the insurance company.

4 International sanctions monitoring

The insurance company has the right to refuse to make payments under the insurance contract, refuse to carry out the policyholder's orders or provide other services under the insurance contract, and terminate the insurance with immediate effect if the policyholder, policyholder's representative or beneficiary:

- is subject to international sanctions or acts on behalf of a private or legal person subject to such sanctions,
- does not comply with the international sanctions applied to it,
- directly or indirectly lends, transfers or otherwise makes available the use of its assets to a business subject to international sanctions, or allows their transfer to a private or legal person subject to international sanctions; or
- knowingly enables the fulfilment of the obligations based on this Agreement through business subject to international sanctions or with the funds of a business or a private or legal person subject to international sanctions.

International sanctions refer to sanctions, financial sanctions, export or import bans, trade embargoes or other restrictions imposed, administered, approved or executed by the Finnish government, United Nations, European Union, United States of America and United Kingdom or their competent authorities or governing bodies, or to administrative asset freezing measures imposed by the Finnish National Bureau of Investigation.

5 Other applicable terms and conditions

The common provisions for personal insurance are applied to this policy.

DISABILITY INSURANCE

1 Key contents of insurance cover

The right to disability benefit arises if the insured suffers permanent loss of working capacity due to illness or injury during the validity of the insurance, and the permanent disability has continued for three months while the insurance is still valid. The prerequisite for compensation payment is that compensation has been claimed when the insured person was alive.

Insured persons are considered to suffer permanent loss of working capacity if they, owing to an illness or injury, are permanently unable to do their previous work and probably any other work which, considering their age and professional skills, can be considered suitable to them and which will ensure a reasonable living.

The insured person is not considered to suffer permanent loss of work ability solely on the grounds that s/he is entitled to early disability pension or some other pension paid on the basis of reduced working capacity.

The compensation amount is the sum entered in the insurance policy. The amount of compensation is determined according to the date on which entitlement to the benefit is established.

The insurance expires when the right to the compensation arises, or at the end of the insurance period during which the insured reaches 63 years of age.

The insurance coverage is Permanent Disability Cover.

2 Exclusions

No benefit is paid if the disability is caused by

- abuse of alcohol, drugs, or the use of an intoxicant
- attempted suicide within a period of one year from the beginning of the insurance.

3 Filing a claim

For payment of compensation, the claimant must provide the insurance company with a medical certificate of permanent disability and an address for payment of the benefit.

4 Other applicable terms and conditions

The common provisions for personal insurance are applied to this policy.

TRAVEL INSURANCE

These insurance terms and conditions are applied to traveller's insurance policies taken out on 6 May 2013 or later (excluding policies in an Easy insurance package).

If your insurance contract includes travel insurance policies taken out before 6 May 2013 or a travel insurance policy included in an Easy insurance package, their respective terms and conditions are applied.

The insurance cover selected for each insured person is stated in the policy document.

1 Territorial limits

Coverage under Pohjola Traveller's Insurance is valid on journeys abroad throughout the world. If it has been separately agreed and the appropriate entry has been made in the policy document with regard to a specific policy, this policy may also be valid on domestic journeys.

A journey abroad refers to a journey outside Finland. It begins when the insured person leaves their home, workplace, study place or holiday home in Finland and ends when they return to any of the aforementioned places. The insurance cover is not, however, valid in the above-mentioned places, nor on journeys between them. Travel in Finland connected with travel abroad forms part of the travel abroad in the event that the travel continues without interruption from the aforementioned places abroad or back from abroad.

Travel in Finland refers to journeys made to places which are more than a straight-line distance of 50 kilometres from the insured person's home, place of work or study, or holiday home. It begins when the insured person leaves their home, workplace, study place or holiday home in Finland and ends when they return to any of the aforementioned places. The insurance cover is not, however, valid in the above-mentioned places, nor on journeys between them.

2 Period of validity

The maximum number of days that coverage is provided from the beginning of a journey is stated in the Pohjola Traveller's Insurance policy document. Insurance coverage ends concerning a journey that has begun after a period that has been entered in the policy document, even if the journey should be longer than that.

A journey abroad that has begun is not considered to end, i.e. a journey or stay abroad is not considered to have been interrupted on account of a visit to Finland of less than 30 days, if the journey from which the insured person has returned has continued without interruption for more than three months and the insured person intends to return to the same destination. Illnesses that have started or accidents that have occurred during a visit to Finland are not coverable as travel illnesses or accidents on a journey abroad.

3 Effect of residence on insurance validity

An insured person must have a factual and permanent home municipality and residence in Finland under the Municipality of Residence Act and the Population Information System at the time of the occurrence of the insured event, in order to be entitled to compensation under the applicable insurance. If, however, an extension to the validity period has been separately agreed upon regarding certain cover under Pohjola Traveller's Insurance and the appropriate entry has been made in the insurance policy, the above requirement is not applied during the extension, nor during an uninterrupted validity period preceding the extension.

4 High-risk areas, nuclear accident and aviation accident

Pohjola Traveller's Insurance is not valid in a country or area to which the Ministry for Foreign Affairs of Finland recommends avoiding travelling or which the Ministry for Foreign Affairs recommends leaving. However, this exclusion will not apply

- during ten days from the date of such recommendation, if the insured person has arrived in the country or a part of the country described above before the Ministry for Foreign Affairs' recommendation, unless a major war is concerned or the insured person has participated in the war or in an armed conflict, or the insured person has participated in peacekeeping operations organised by the United Nations, the European Union or another community or organisation, or some other military operation

- if the insured person's insurance event is not due to the reason why the Ministry for Foreign Affairs issued its recommendation.

If it has been separately agreed upon concerning certain coverage under Pohjola Traveller's Insurance and the appropriate entry has been made in the insurance policy to provide cover in high-risk areas, this cover will also be valid in a country or a part of the country to which the Ministry for Foreign Affairs of Finland recommends avoiding travelling or which the Ministry for Foreign Affairs of Finland recommends leaving, even if the insured person's insurance event has resulted from the reason why the Ministry issued its recommendation. Extending the cover to include a high-risk area does not, however, extend the cover to a major war or situations in which the insured person participated in a war or an armed conflict. Irrespective of the extension, the cover is not valid if the insured person has participated in peacekeeping operations organised by the United Nations, the European Union or another community or organisation, or another military operation.

The insurance does not cover damage or loss caused by a nuclear accident as described in the Nuclear Liability Act, or by damage caused by material, equipment or weapons based on nuclear reaction or ionising radiation, regardless of where the nuclear accident occurred.

In the event of illness, injury or death occurring in connection with an aviation accident, Pohjola Traveller's Insurance does not cover pilots or any other persons who are members of the flight crew or persons carrying out other duties relating to the flight in either hobby or professional aviation. Aviation sports, however, may be insured separately as special sports in accordance with clause 2.3.3 of the terms and conditions of Pohjola Traveller's Insurance. However, special sports do not cover professional aviation.

5 Applicability of General Contract Terms and Conditions

The General Contract Terms and Conditions are applied in all insurance policies.

POHJOLA TRAVELLER'S INSURANCE

1 Insurance coverage

The following types of coverage are available:

- Traveller's Medical Treatment Cover
- Traveller's Disability Cover
- Traveller's Death Cover
- Traveller's Daily Allowance Cover
- Traveller's Crisis Cover
- Travel Cancellation Cover
- Travel Interruption Cover
- Delayed Departure Cover
- Missed Departure Cover.

The types of cover for each insured person are stated in the policy document.

2 Common provisions to all coverage under Pohjola Traveller's Insurance

2.1 Those insured

Those insured are the persons named in the insurance policy.

2.2 Beneficiary

The policyholder may name a beneficiary to whom any compensation is paid. Such a beneficiary clause and relevant alterations or cancellations affecting it must be submitted to the insurance company in writing.

Compensation with the exception of Death Cover is paid to the insured person unless the policyholder has determined another beneficiary. When the insured person is a foetus, the beneficiary is the mother until birth.

2.3 Validity during sports

In motor sports, motor liability insurance is the primary source of compensation for losses covered under motor liability insurance, as against the Traveller's Medical Treatment Cover included in Pohjola Traveller's Insurance.

2.3.1 Definition of competitive sports

Competitive sports refer to competitions or matches arranged by a sports association or club, training arranged according to a training programme, and other training typical of the sport, regardless of the level of competitiveness or the age of the insured person.

Training arranged according to a training programme refers to training carried out following either a written or verbal training plan (the coach does not have to be present).

Other training typical of the sport refers to training that supplements the main sport when carried out as part of preparation to games or sports.

2.3.2 Competitive sports

Traveller's Medical Treatment Cover, Traveller's Daily Allowance Cover and Travel Interruption Cover are not valid in competitive sports.

If it has been separately agreed and the appropriate entry has been made in Traveller's Medical Treatment Cover or Travel Interruption Cover (comprehensive cover), this cover is nevertheless valid in the sports specified in the policy document. They are nevertheless never valid for high-risk sport competitions referred to in clause 2.3.4.

However, Traveller's Disability Cover and Traveller's Death Cover are valid in competitive sports.

2.3.3 Special sports

Traveller's Medical Treatment Cover, Traveller's Daily Allowance Cover and Travel Interruption Cover are not valid in any of the sports listed below, referred to in these terms and conditions as special sports. The above applies regardless of whether the insured person is competing in any of the sports or not.

If it has been separately agreed and the appropriate entry has been made with reference to Traveller's Medical Treatment Cover or Travel Interruption Cover (comprehen-

sive cover), this cover is nevertheless valid in all the special sports listed below. However, the insurance is not valid for competitions in such special sports. Competitive sports have been specified in clause 2.3.1.

However, Traveller's Disability Cover and Traveller's Death Cover are valid in special sports.

Special sports are:

- combat sports, self-defence sports and martial arts
- winter sports: luge and freestyle skiing as well as speed and downhill skiing
- aviation, such as hot air and gas ballooning, motorised flying, hang- and paragliding, microlight flying, parachuting, indoor skydiving, flying with amateur-built aircraft, and use of gliders and motor gliders
- Strength sports: powerlifting, weightlifting and body building
- scuba diving
- other special sports: BMX cycling, bungee jumping, parasailing, skimbat or kite surfing, sailboarding and flyboarding, parkour, abseiling, acrobatics and free running.

2.3.4 High-risk sports

Traveller's Medical Treatment Cover, Traveller's Daily Allowance Cover and Travel Interruption Cover are not valid in the sports listed below, referred to in these terms and conditions as high-risk sports. The above applies regardless of whether the insured person is competing in any of the sports or not.

If it has been separately agreed and the appropriate entry has been made in Traveller's Medical Treatment Cover or Travel Interruption Cover (comprehensive cover) in the insurance policy, this cover is nevertheless valid in the sports listed below as high-risk sports. This also means that coverage extends to competitive events in such sports. Competitive sports have been specified in clause 2.3.1.

However, Traveller's Disability Cover and Traveller's Death Cover are valid in high-risk sports.

High-risk sports are:

- American football
- Australian football
- Rugby
- Lacrosse
- Mixed Martial Arts
- Wrestling
- Off-piste skiing
- Ice and rock climbing
- Glacier and mountain climbing
- Strength athletics
- Downhill biking
- Downhill skating
- Ocean sailing
- BASE jumping
- trekking into uninhabited areas, such as research expeditions or treks to mountains, jungles, deserts or wilds or other similar areas abroad
- Wildwater canoeing
- Freediving
- Roller derby
- Other sports where the risks are at a similar level.

2.4 Effect of the insured person's age on validity

Traveller's Daily Allowance Cover expires at the end of the insurance period during which the insured reaches 70 years of age. Other insurance coverage expires at the end of the insurance period when the insured person turns 100.

2.5 Travel illness

2.5.1 Travel illness

Travel illness is defined as an illness requiring medical treatment and which started, or its first symptoms appeared (with the insurance still being valid), during the journey and for which medical treatment was given during the journey or within 14 days of the end of the journey.

2.5.2 Travel illness does not include

Travel illness does not include

- mountain sickness
- illness caused by abuse of medicine or use of alcohol or other intoxicant
- illness that started before the journey or the symptoms of which appeared before the journey. An illness as described above is not considered a travel sickness even if it suddenly becomes worse during the journey or its state changes. Neither is it considered a travel illness when the worsening or change in the state of the illness was not likely or expected on the basis of general medical experience. Even in cases of travel illness, any illness that began or showed its first symptoms before the journey is compensated as specified in clause 3.2.3 of Traveller's Medical Treatment Cover.
- illness that started in connection with a medical examination or treatment, unless this was carried out for the treatment of a travel accident or illness compensated from the same insurance
- illnesses, pain or other symptoms of the teeth, periodontium or masticatory system. Even in cases that are not considered travel illnesses or accidents, sudden dental pain, dental paint treatment and injury to a tooth caused by chewing are nevertheless compensated, as specified in clause 3.2.2 of Traveller's Medical Treatment Cover. A dental injury caused by a travel accident is handled according to the terms and conditions in Traveller's Medical Treatment Cover.
- termination of pregnancy or infertility or related illnesses or complications
- pregnancy or childbirth or related illnesses or complications.

Extension for pregnancy when the insured person is a foetus:

When the insured is still unborn, the above restriction related to pregnancy and childbirth is nevertheless not applied in a child's Traveller's Medical Treatment Cover in cases of sudden change in the pregnancy requiring immediate care and if the change according to general medical experience was not likely or predictable. In cases like this Traveller's Medical Treatment Cover provides cover up to the birth as specified in the terms and conditions for the treatment of both child and mother to the extent that is necessary for the health of the child.

2.6 Travel accident and exclusions

2.6.1 Travel accident

A travel accident is a sudden, external occurrence which is beyond the control of the insured, which takes place during the journey while the insurance is valid and causes bodily injury.

The following are also considered to be travel accidents: unintentional drowning, heatstroke, sunstroke, hypothermia, injury caused by considerable variation in atmospheric pressure, gas poisoning sustained by the insured, and poisoning caused by a substance taken inadvertently.

2.6.2 Excluded from coverage as travel accidents

Coverable travel accidents do not include injuries caused by

- an event arising from an illness, defect or injury of the insured
- operation, treatment or other medical procedure, unless the procedure is undertaken under the same policy in order to treat an injury or travel illness caused by a coverable travel accident
- poisoning due to medicine, alcohol or other intoxicant used by the insured, or due to a substance taken as food
- biting on a tooth or dentures, even though an external factor has contributed to the damage. However, damage to a tooth caused by biting is compensated as specified in clause 3.2.2.
- suicide or attempted suicide.

Excluded from coverage as travel accidents

- hernia of the intervertebral disk, abdominal or inguinal hernia, a rupture of an Achilles tendon, long head of biceps tendon or rotator cuff, or recurrent dislocation, unless the injury was caused by an accident that would also cause injury to healthy tissues
- infectious diseases caused by a bite or sting
- the psychological consequences of an accident.

2.6.3 Effect of illness, defect, injury or degeneration not related to travel accident

The insurance does not cover illness, defect, injury, or degeneration of the musculoskeletal system not related to a travel accident, even if they had been symptom-free before the accident. If these factors not related to the travel accident have materially contributed to the emergence of the injury sustained during the journey or its delayed recovery, compensation from Traveller's Medical Treatment Cover, Traveller's Daily Allowance Cover and Traveller's Disability Cover will only be paid to the extent that the expenses, disability or permanent disability are deemed to have been caused by the travel accident.

2.7 Reasonableness of expenses

If it becomes apparent that the claimed expenses substantially exceed the generally accepted and applied reasonable level of prices and costs at the destination, the insurance company has the right to lower the amount of compensation but not, however, below the reasonable level.

2.8 Insurance company's right to decide on place of treatment

The insurance company has the right to decide where the insured person's examinations and treatment are carried out, provided this does not cause unreasonable inconvenience to the person.

3 Traveller's Medical Treatment Cover

3.1 Key contents of insurance cover

The insurance compensates, as specified in these terms and conditions, expenses caused by travel illnesses that began or travel accidents that occurred during the validity of the insurance.

The insurance also covers, to the extent specified herein, sudden tooth ache; injury to tooth caused by biting; sudden deterioration of illness before a journey; and expenses caused by a journey being interrupted or extended. Compensation can only be paid if the symptoms appear and injury took place during the policy's validity period. The insurance also covers repatriation costs if the insured person dies during a journey and the policy is valid.

Compensation is only payable if the expenses are incurred while the policy is in force.

Indemnifiable events must occur within a period, specified in the insurance policy, from the beginning of the journey.

A deductible specified in the insurance policy is subtracted from coverable expenses per each illness, accident or other coverable event. The size of the deductible in accidents depends on when the accident occurred, and in illnesses on when the illness examinations or treatment began.

Expenses are coverable insofar as they do not grant or would not have granted entitlement to compensation under the Health Insurance Act, Motor Liability Insurance Act, Workers' Compensation Act, Patient Injury Act or corresponding foreign legislation or other laws.

3.2 Coverable expenses

3.2.1 Travel illnesses and travel accidents

Expenses are covered provided that the examination or treatment of illness or injury is prescribed by a physician. In addition, the examination or treatment procedures must be in accordance with generally accepted medical practice and necessary for the treatment of the illness or injury in question.

Of these expenses, the following are coverable:

- reasonable fees for examination and treatment procedures carried out by physicians or healthcare professionals
- costs of pharmaceutical products and wound dressings sold at pharmacies
- daily hospital charges
- reasonable travel expenses to a local physician or a hospital/clinic. Costs incurred by the insured person using his/her own car or hired car are covered to the maximum amount of motor vehicle travel costs specified under the decree issued by the Ministry of Social Affairs and Health on the basis of the Health Insurance Act.
- costs of an orthopaedic brace if it was the first orthopaedic brace acquired after a coverable operation or accident. These expenses are only covered up to EUR 500 per operation or accident
- rental costs of forearm or underarm crutches
- costs for physiotherapy prescribed by a physician to recover from a fracture or surgery or plaster treatment. Physiotherapy is also covered in knee and shoulder illnesses or injuries in which physiotherapy is applied instead of surgery. However, physiotherapy is only covered for a maximum of 10 sessions per travel illness or accident.

The following are also reimbursed when related to travel illness or travel accident

- necessary telephone charges incurred during the journey, up to EUR 200
- necessary expenses for purchase of essential commodities related to the medical treatment up to EUR 200, provided that such commodities are not, according to local practice, included in the hospital treatment.

The insurance company may require that the insured be transported, at the insurance company's expense, back to Finland for treatment if local treatment would otherwise cause substantially higher expenses as compared to similar treatment in Finland. If the insured does not accept the suggested arrangement, the insurance company undertakes to indemnify for expenses incurred from treatment given abroad up to an amount corresponding to expenses incurred from repatriation of the insured to Finland and treatment given in Finland.

Expenses caused by travel illness are reimbursed for no longer than the period specified in the insurance policy from the date of the first treatment or examination of the illness. Expenses incurred due to a travel accident are covered for a maximum of three years after the accident.

3.2.2 Sudden toothache and dental injury caused by biting

Medical treatment expenses incurred from necessary treatment of sudden toothache that started on a journey, including reasonable local travel expenses, are covered up to a maximum total of EUR 300, provided that the ache began and treatment was given during the journey and that the insurance was still valid.

We compensate necessary medical treatment expenses and local travel expenses incurred during a journey from treatment of injury caused by biting on a tooth or dentures up to a maximum total of EUR 300, provided that the injury occurred and treatment was given during the journey and that the insurance was still valid.

Only those expenses are reimbursed that were incurred from the first day of the journey for a period entered as the insurance's validity in the policy document.

3.2.3 Sudden deterioration of an illness that existed before a journey

Compensation for expenses caused by illness that began or whose symptoms appeared before the journey will be paid when it is a case of sudden deterioration or change of illness during the journey if the policy is valid, and provided the deterioration or change were not foreseeable on the basis of general medical experience. Only acute, emergency-type medical treatment given at the destination is covered as expenses. Expenses will be covered for no more than 7 days from the first day of treatment, unless otherwise specified in the insurance policy.

3.2.4 Repatriation of a deceased

If the insured dies during the journey – and the policy is valid at the time - the insurance will cover the insured person's reasonable expenses for repatriation to Finland or reasonable funeral expenses abroad. These expenses will be paid regardless of the cause of death.

3.2.5 Travel interruption or delayed return

The following items, 1–4, owing to travel interruption or delayed return will only be reimbursed if caused by travel illness or accident. Another condition for compensation is that the travel illness or travel accident is of the kind that the patient's condition judged on medical grounds makes it necessary to return to Finland or to remain in the travel destination contrary to the original itinerary. The compelling nature of the reason is assessed purely on medical grounds. In situations like this, compensation is paid in cases of interruption of journey or delayed return for

1. necessary and reasonable extra travel and accommodation costs caused to the insured person during the journey when the journey must be interrupted or the return delayed owing to the insured person's travel illness or accident
2. necessary and reasonable travel and accommodation costs incurred to the insured person because a travelling companion's journey is interrupted or return delayed, owing to the latter's travel illness, travel accident or death. The condition for compensation to be paid is that the travelling companion's condition is serious. Such expenses are only reimbursed to one person per another person who fell ill or was injured.

If approval has been received from the insurance company in advance, the following may also be reimbursed in cases of travel interruption or delayed return

3. costs for medically necessary repatriation of the insured and of the travel expenses of a person who must accompany the insured out of medical necessity

4. reasonable travel and accommodation costs of one next of kin from Finland to the insured person and back to the next of kin's home in Finland, provided the insured person's life is by medical assessment at risk owing to a travel illness or accident.

If the journey is delayed or interrupted because the insured or person travelling with the insured refuses treatment, no extra travel or accommodation costs are reimbursed.

If the insured person's journey is interrupted because his or his travelling companion's close relative in Finland falls seriously ill unexpectedly and suddenly or has a serious accident or dies, the insured person's necessary and reasonable extra accommodation and travel expenses back to Finland are reimbursed.

Expenses will be reimbursed only if the condition of the close relative in Finland is life-threatening.

By next of kin we refer to the insured person's relative, the insured person's partner, or the insured person's partner's relative. However, any cousins or more distant relatives are not considered next of kin. 'Partner' refers to a person to whom the insured person is married or with whom the insured person is in a civil partnership or cohabits with.

By travelling companion we refer to up to two persons in addition to the insured person or a family with which the insured person has jointly made the travel reservations and gone for a trip together.

Extra travel and accommodation costs refer to costs incurred by the insured in addition to those paid in advance.

Expenses are only reimbursed during the period specified in the insurance policy from the date of the accident, or first examination or beginning of treatment of an illness.

3.3 Expenses which are not covered

Expenses are not reimbursed if they are caused by

- examination or treatment provided by a physiotherapist, foot therapist, chiropractor, osteopath, naprapathy practitioner, masseur or equivalent healthcare professional, with the exception of the situation specified in the last but one item of section 3.2.1 above. Even then, a maximum of 10 treatments per insurance event are compensated and for no longer than the period specified in the insurance policy from the date of the first treatment or examination of the illness or the date of the accident.
- purchase of micronutrient, mineral or vitamin preparations
- purchase of nutritional products including clinical nutritional products
- purchase of anthroposophic or homeopathic products
- medical equipment or other aids, orthotic insole or other insole or artificial limb (however, the rental costs of forearm or underarm crutches are reimbursed)
- treatment of an addiction to drugs, alcohol, medicine, nicotine or other similar substance, or from treatment of other types of addiction
- costs of an orthopaedic brace unless it was the first orthopaedic brace acquired after a coverable operation or accident. In cases like this, too, these expenses are only covered up to EUR 500 per operation or accident.
- spending time or staying at a place providing rehabilitation services or any actual services used
- services of a unit providing social welfare or residential services even though they may also include healthcare services.

Indirect expenses, such as having a car, other means of transport or luggage delivered home, lost income, meal, parking or other similar costs are not reimbursed.

Expenses are not reimbursed if the right by law to compensation has been lost, owing to the neglect of some insurance-related responsibility.

Expenses are not reimbursed if the same expense has already been reimbursed or if compensation has been sought from another cover or insurance policy.

3.4 Filing a claim

3.4.1 Notification of journey and illness or accident

The claimant must submit to the insurance company a written clarification of the journey, illnesses and accidents or death. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

3.4.2 Receipts

The claimant must pay medical treatment expenses personally before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming for compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must upon request provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

Claimants must also pay any other costs themselves and subsequently claim compensation they are entitled to by law from those responsible. If expenses have not been reimbursed by virtue of law, original receipts or equivalent documentation of them must be sent upon request to the insurance company.

3.4.3 Loss investigation costs

Fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

3.5 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

4 Traveller's Disability Cover

4.1 Key contents of insurance cover

The right to compensation arises if the insured suffers permanent handicap caused by a travel accident which occurred during the validity of the cover and the permanent handicap has continued for three months, with the cover being valid throughout that time.

Permanent disability refers to a medically assessed general handicap which the insured has incurred through an injury and which, according to medical prognosis, is unlikely to be healed. In determining the handicap, only the nature of the injury is taken into account. The individual circumstances of the injured person, such as their profession or leisure-time pursuits, do not affect the determination of the handicap.

The degree of handicap is determined in accordance with the disability category decree issued by the Government on the basis of the Workers' Compensation Act and valid when the travel accident occurred. Injuries are divided into disability categories 1–20, with category 20 corresponding to full handicap and category 1 to the smallest coverable handicap.

The benefit for full, permanent handicap as per class 20 is paid as a lump sum equal to the sum entered in the insurance policy valid at the time the travel accident occurred. For partial, permanent handicap, the benefit is paid as a lump sum equal to as many twentieths of the sum as indicated by the handicap class.

A handicap is considered permanent once it has been medically diagnosed as such, and this can be done no sooner than three months and no later than three years after the accident. The cover must be valid at this time.

If the degree of handicap changes by at least two disability categories before three years have elapsed since the travel accident, the amount of benefit must be revised correspondingly, provided the Disability Cover is still valid. However, no benefit already paid will be recovered.

The benefit will be paid under the insurance terms and conditions valid at the time of the travel accident.

4.2 Exclusions

No benefit is paid for the psychological consequences of a travel accident.

4.3 Filing a claim

The claimant must notify the insurance company of the journey and travel accident in writing. by filling in the insurance company's loss report, accompanied by any other relevant documentation.

In order for the disability benefit to be processed, the claimant must send, upon request, an E Doctor's statement to the insurance company, describing the handicap. The fee for a doctor's statement is reimbursed only if the insurance company has specifically requested for one.

4.4 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

5 Traveller's Death Cover

5.1 Key contents of insurance cover

The right to compensation arises if the insured dies as a result of a travel accident which occurred during the validity of the cover.

The compensation is the sum entered in the insurance policy valid at the time of the travel accident.

The benefit will be paid under the insurance terms and conditions valid at the time of the travel accident.

5.2 Exclusions

The benefit is not paid if the insured dies after three years have elapsed since the travel accident occurred. Moreover, no benefit is paid for the psychological consequences of a travel accident.

5.3 Filing a claim

The claimant must notify the insurance company of the journey and travel accident in writing.

For the processing of death benefit, the claimant must provide the insurance company with a death certificate for the insured and official extracts from the population register or equivalent, on beneficiaries. The insurance company must also be sent, upon request, further documentation by the authorities on the cause of death.

Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

5.4 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

6 Traveller's Daily Allowance Cover

6.1 Key contents of insurance cover

The right to compensation arises if the insured who is in an employment relationship becomes unable to work as a result of a travel accident which occurred during the validity of the cover.

A daily compensation to the amount that was entered in the insurance policy on the date of the travel accident will be paid for days when the insured is fully unable to do the work he has been employed to do, and when work disability is only partial, the amount corresponding to the amount of work disability will be paid. Compensation will only be paid for the days when the cover is valid.

The insured will be considered fully unable to work if owing to a travel accident that occurred while the cover was valid, he is – judged on medical grounds – unable to perform any of his usual work duties. The insured will be considered partly unable to work if owing to a travel accident that occurred while the cover was valid, he is – judged on medical grounds – unable to perform some of his usual work duties.

The compensation is paid for as many days as the incapacity for work continues in excess off the qualifying period mentioned in the policy. The qualifying period will be subtracted once per each accident. The qualifying period begins on the first day of the incapacity for work as stated by a physician.

Benefit for any single travel accident is paid up to the maximum period stated in the policy document.

The benefit will be paid under the insurance terms and conditions valid at the time of the travel accident.

The cover expires at the end of the insurance period during which the insured reaches 70 years of age.

6.2 Exclusions

Compensation will not be paid

- for psychological consequences of a travel accident
- if the insured is not in an employment relationship when the travel accident occurs.

6.3 Filing a claim

The claimant must notify the insurance company in writing of the journey and the travel accident and of any current work relationships by filling in the insurance company's loss report, accompanied by any other relevant documentation.

For the purposes of having the daily benefit application processed, the claimant must submit documentation to us showing the disability period and the reason for the disability. A tax card must also be sent to us for payment of the benefit.

Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

6.4 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

7 Traveller's Crisis Cover

7.1 Key contents of insurance cover

The policy covers evacuation expenses, psychotherapy expenses and cancellation costs caused by the reasons specified in the insurance terms and conditions.

Compensation is only payable if the expenses are incurred while the policy is in force. The event based on which compensation is sought must also have occurred while the policy was in force.

Moreover, for an event to be indemnifiable, it must occur within a certain period of time after the start of the covered trip as specified in the policy document. Only cancellation costs that are incurred within the period calculated from the first day of the cancelled trip as specified in the policy document can be reimbursed.

Expenses are only covered insofar as they are not or would not have been coverable under the Finnish Health Insurance Act, the Finnish Motor Liability Insurance Act, the Finnish Workers' Compensation Act or another act, and only to the extent that the insured is not or would not have been entitled to compensation from the tour operator, travel agent, hotel, transport company or equivalent.

Expenses are not reimbursed under this policy if a statutory right to compensation has been lost due to neglect of insurance obligations.

Evacuation expenses, psychotherapy expenses and cancellation costs are reimbursed up to the maximum amount specified in the policy document for each event. Expenses are reimbursed up to the maximum amount that was in force when the event on the basis of which compensation is sought occurred.

The deductible payable by the policyholder for each event is the amount specified in the policy document that was in force when the event on the basis of which compensation is sought occurred.

7.2 Coverable events and exclusions to them

7.2.1 Evacuation and psychotherapy expenses

Evacuation and psychotherapy expenses are reimbursed when they were caused at the travel destination by

- a sudden natural catastrophe
- a sudden epidemic constituting a public hazard or
- a sudden armed conflict or act of terror

which could not have been foreseen.

'Natural catastrophe' refers to earthquakes, volcanic eruptions, landslides, tsunamis and floods or other similar major natural disasters.

'Epidemic' refers to a sudden and unforeseeable outbreak of an infection that affects large groups of people or a large geographic area.

Expenses are reimbursed only if the Finnish Ministry for Foreign Affairs, a Finnish embassy or equivalent authority has noted the event that led to the evacuation and recommends people to leave the travel destination.

Another requirement is that the insured person follows the instructions provided by the Finnish Ministry for Foreign Affairs, a Finnish embassy or equivalent authority.

Moreover, psychotherapy expenses will be reimbursed if they were incurred while the policy was valid during the journey and

- the insured person or a travelling companion has been the target of a violent crime or its attempt
- the insured person or a travelling companion has been involved in a road accident or accident involving watercraft or aircraft
- a significant fire broke out in the building where the insured was accommodated.

By travelling companion we refer to a person with whom the insured person has jointly made the travel reservations and gone for a trip together.

The crime or attempted crime must be notified to the police.

Compensation will not be paid if

- a violent crime or its attempt or burglary was committed or a fire caused by the partner or common-law partner, child, sibling or parent of the insured, or a person residing in the same household as the insured

- the travel destination is in an area to which the Ministry for Foreign Affairs of Finland or other Finnish authority has banned travel or recommended that you do not travel before that journey began
- the insured has taken part in an armed conflict, a peacekeeping operation organised by the United Nations, the European Union or other organisation, or in some other military operation.

7.2.2 Cancellation costs

Cancellation costs are reimbursed when they were caused by any of the following at the travel destination before the beginning of the journey

- a sudden natural catastrophe
- a sudden epidemic constituting a public hazard or
- a sudden armed conflict or act of terror

at the travel destination that could not have been foreseen when the trip was booked.

Compensation is payable provided that the event occurs less than 60 days before the start of the trip and the event can be deemed to cause an adverse effect on conditions at the travel destination at the time when the trip is due to begin.

Travel cancellation costs are also reimbursed in the event of an epidemic at the travel destination that may be deemed on medical grounds to pose a hazard to an unborn child if the insured person, the spouse of the insured person or a person travelling with the insured is pregnant. Compensation is payable provided that the hazard could not be foreseen when the trip was booked.

'Natural catastrophe' refers to earthquakes, volcanic eruptions, landslides, tsunamis and floods or other similar major natural disasters.

'Epidemic' refers to a sudden and unforeseeable outbreak of an infection that affects large groups of people or a large geographic area.

'Spouse' refers to a person to whom the insured person is married or with whom the insured person is in a civil partnership or cohabits.

'Travel companion' refers to up to two persons in addition to the insured person or a single family with whom the insured person has made the travel reservations and arranged to go on the trip.

Expenses are reimbursed only if the Finnish Ministry for Foreign Affairs, a Finnish embassy or equivalent authority has noted the event that led to the cancellation and recommends people to refrain from travelling to the destination.

7.3 Coverable expenses

7.3.1 Evacuation expenses

Coverable expenses include the insured person's reasonable and necessary travel and accommodation costs which

- are necessary in order for the insured to continue according to the original itinerary that was insured or
- were caused by the return trip to Finland from the incident location.

The incident location we mean the place where a natural catastrophe, armed conflict, terrorist act or epidemic defined in these terms and conditions occurred.

Extra travel and accommodation costs refer to costs incurred by the insured in addition to those paid in advance.

Extra travel expenses cover ticket prices only up to tourist class.

The insured must personally arrange the travel and accommodation services for which compensation is sought.

7.3.2 Psychotherapy costs

We cover costs for psychotherapy given by a psychotherapist approved by the Finnish National Supervisory Authority for Welfare and Health (Valvira).

The prerequisite for compensation payment is that treatment has been sought within three months of the event for which compensation has been applied. Expenses are reimbursed for a maximum of six months from the coverable insurance event. Expenses are only reimbursed for psychotherapy provided in Finland and only for up to ten sessions per insurance event.

If psychotherapy is provided in the form of couple, family or group therapy, only the insured person's share of the therapy is covered.

7.3.3 Travel cancellation costs

The insurance covers expenses paid in advance incurred by the cancellation of the insured travel when the insured person missed the departure for a compelling reason specified in the terms and conditions.

The tour operator or other service provider must be contacted to cancel a journey or other service as soon as it is clear that cancellation is necessary. If the journey is not cancelled, we only compensate from Crisis Cover the part of the insured person's expenses which according to the law or the terms and conditions of the tour operator or other service provider would have been the insured person's responsibility if the journey had been cancelled.

7.4 Expenses which are not covered

Coverable expenses do not include

- loss of bonus points, RCI points or equivalent
- loss of income or indirect costs, such as those arising from applying for compensation, meal and parking costs or other equivalent costs
- expenses that have already been reimbursed or for which compensation has been sought from another cover or insurance policy.

7.5 Filing a claim

7.5.1 Itinerary and loss report

The claimant must provide the insurance company with a written itinerary and a description of the event on the basis of which compensation is sought. This is done by filing a loss report with the insurance company. If requested, additional information must also be provided in order to settle the claim.

7.5.2 Receipts

The claimant must pay medical treatment expenses personally before claiming compensation from the insurance company. Original payment receipts must be submitted upon request to the insurance company.

If the reimbursement under the Health Insurance Act included in the treatment expense has not been deducted in connection with the payment of the expense, the claimant must also submit a claim for reimbursement of the treatment expenses under the Health Insurance Act before claiming compensation from the insurance company. Claims under the Health Insurance Act must be submitted to the Social Insurance Institution within six months of paying the medical treatment expenses. The claimant must upon request provide the insurance company with the original receipt for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

Claimants must also pay any other costs themselves and subsequently claim compensation they are entitled to by law from those responsible. If expenses have not been reimbursed by virtue of law, original receipts or equivalent documentation of them must be sent upon request to the insurance company.

7.5.3 Loss investigation costs

Fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

7.6 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

8 Travel Cancellation Cover

8.1 Key contents of insurance cover

The cover compensates, during its validity, travel cancellation when the insured person missed the departure for a compelling reason specified in the insurance terms and conditions.

Compensation will be paid only if the reason for the cancellation appeared and the journey was cancelled while Travel Cancellation Cover was valid.

Only those expenses are reimbursed that were incurred from the first day of the cancelled journey for a period entered as the insurance's validity in the policy document.

Expenses are only covered insofar as they are not or would not have been coverable under some Act or by a tour operator, travel agent, hotel, transport company or equivalent.

Costs are reimbursed up to the maximum amount that is entered in the policy document per cancelled journey. Costs are reimbursed according to the maximum amount of compensation that was valid when the reason for the cancellation became known.

A deductible referred to in the insurance policy that was valid when the reason for the cancellation became known is subtracted from each cancelled journey.

8.2 Coverable cancellations and exclusions to them

8.2.1 Coverable events entitling to compensation under basic coverage

As cancellation, we compensate a journey that could not be started owing to a compelling reason attributed to any of the following:

- sudden illness, accident or death suffered by the insured
- substantial loss of or material damage to the insured person's property in Finland. Substantial property damage does not, however, include loss of or damage to money, payment instruments or vehicles.
- serious, unexpected and sudden illness, serious accident or death of a next of kin of partner's next of kin
- serious, unexpected and sudden illness, serious accident or death of travelling companion
- serious, unexpected and sudden illness, serious accident or death of travelling companion's next of kin or travelling companion's partner's next of kin.

By sudden illness we also mean a sudden deterioration of an illness which the insured person had had for long time, provided such a deterioration was not medically likely or predictable when the journey was booked.

The compelling nature of the reason related to either illness of accident is assessed purely on medical grounds.

With reference to property damage, a reason is considered compelling if the insured person's presence is required at the site of the loss.

By next of kin we refer to the insured person's relative, the insured person's partner, or the insured person's partner's relative. However, any cousins or more distant relatives are not considered next of kin. 'Partner' refers to a person to whom the insured person is married or with whom the insured person is in a civil partnership or cohabits with.

'Travel companion' refers to up to two persons in addition to the insured person or a single family with whom the insured person has made the travel reservations and arranged to go on the trip.

8.2.2 Coverable events entitling to compensation under comprehensive coverage

As cancellation, we compensate a journey that could not be started owing to a compelling reason attributed to any of the following:

- sudden illness, accident or death suffered by the insured
- substantial loss of or material damage to the insured person's property in Finland. Substantial property damage does not, however, include loss of or damage to money, payment instruments or vehicles.
- serious, unexpected and sudden illness, serious accident or death of a next of kin of partner's next of kin
- serious, unexpected and sudden illness, serious accident or death of travelling companion
- serious, unexpected and sudden illness, serious accident or death of travelling companion's next of kin or travelling companion's partner's next of kin.

By sudden illness we also mean a sudden deterioration of an illness which the insured person had had for long time, provided such a deterioration was not medically likely or predictable when the journey was booked.

The compelling nature of the reason related to either illness of accident is assessed purely on medical grounds.

With reference to property damage, a reason is considered compelling if the insured person's presence is required at the site of the loss.

'Travel companion' refers to up to two persons in addition to the insured person or a single family with whom the insured person has made the travel reservations and arranged to go on the trip.

The insured is also entitled to compensation if s/he cannot go on the journey because s/he

- becomes unemployed or is laid off
- has been invited to a wedding, christening or confirmation taking place during a scheduled paid-for journey
- attends a funeral that takes place during a scheduled paid-for journey
- divorces
- has been summoned as a witness in court during a scheduled paid-for journey
- the insured person has been ordered to attend a military refresher course or the Ministry has ordered the person to attend non-military supplementary service, coinciding with the period of a journey already paid for
- any of the above reasons has prevented his/her partner, insured underage child or underage insured person's parent from joining them on a journey as planned
- if any of the reasons above has prevented his/her travelling companion's travel.

By next of kin we refer to the insured person's relative, the insured person's partner, or the insured person's partner's relative. However, any cousins or more distant relatives are not considered next of kin. 'Partner' refers to a person to whom the insured person is married or with whom the insured person is in a civil partnership or cohabits with.

8.2.3 Events not compensated from Travel Cancellation Cover

Travel Cancellation Cover does not apply, either under basic or comprehensive coverage if

- the reason for the cancellation became apparent before Travel Cancellation Cover became valid
- the reason for the cancellation became apparent before the reservation or payment of the journey
- coverage began later than three days prior to the beginning of the journey
- the reason for the cancellation is the insured's fear of flying or contagious disease or other phobia
- a sudden illness or deterioration of a pre-existing condition causing the cancellation was the result of drug abuse, or the use of alcohol or some other intoxicating substance.

8.3 Coverable expenses

We compensate expenses paid in advance for which the insured person is responsible according to the tour operator's or other service provider's terms and conditions, and which the tour operator or other service provider is not obliged to return by law, or under the travel terms and conditions or other conditions.

The tour operator or other service provider must be contacted to cancel a journey or other service as soon as it is clear that cancellation is necessary. If the journey is not cancelled, we only compensate from Travel Cancellation Cover the part of the insured person's expenses which, according to the law or the terms and conditions of the tour operator or other service provider, would have been the insured person's responsibility if the journey had been cancelled.

8.4 Expenses which are not covered

Coverable expenses do not include

- loss of bonus points, RCI points or equivalent
- indirect costs, such as those arising from applying for compensation
- expenses that have already been reimbursed or for which compensation has been sought from another cover or insurance policy.

8.5 Filing a claim

8.5.1 Documentation for cancellation of a journey

The claimant must submit to the insurance company written documentation on the itinerary, cancellation of journey, the reason for the cancellation, the losses and any remuneration provided by the tour operator or other service provider. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

8.5.2 Receipts

Claimants must first pay for the expenses for which they are responsible by law and under the terms and conditions or the tour operator or other service provider and subsequently claim compensation from those liable for them. If expenses have not been reimbursed by virtue of law or according to the tour operator or other service provider, the claimant must submit upon request original receipts or equivalent documentation of them to the insurance company.

8.5.3 Loss investigation costs

Doctor's fees, other medical treatment expenses or fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

8.6 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

9 Travel Interruption Cover

9.1 Key contents of insurance cover

Compensation is paid in accordance with these terms and conditions when the insured person's journey is interrupted for a reason referred to in the terms and conditions.

Compensation will only be paid if the reason for the interruption became apparent or the loss took place during the validity of the insurance.

Moreover, for an event to be indemnifiable, it must occur within a certain period of time after the start of the covered trip as specified in the policy document. Only those expenses are reimbursed that were incurred from the first day of the interrupted journey for a period entered as the insurance's validity in the policy document. However, the expenses of a new one-way journey necessary for work or study will be reimbursed even if this took place after this period.

Expenses are only covered insofar as they are not or would not have been coverable under some Act or by a tour operator, travel agent, hotel, transport company or equivalent.

Expenses are usually reimbursed up to a maximum total of a sum entered in the insurance policy per incident that caused the interruption. Costs are reimbursed according to the maximum amount of compensation that was valid when the reason for the interruption became known.

We will subtract the deductible per insurance event that was entered in the insurance policy and valid when the reason for the interruption became apparent.

9.2 Coverable events and exclusions to them

9.2.1 Coverable insurance events

Journey interruption expenses are reimbursed if a journey is interrupted because the insured person or a travelling companion falls ill or is injured at the travel destination or because the insured person has to return to the final destination in Finland prematurely for a reason specified in the insurance terms and conditions.

Journey interruption is compensated provided there was a compelling reason for the interruption:

- illness, accident or death of the insured during the journey
- travel illness, accident or death of travelling companion
- substantial loss of or material damage to the insured person's property in Finland. Substantial property damage does not, however, include loss of or damage to money, payment instruments or vehicles.

With regard to returning to Finland early, the condition for compensation is that the travel illness or travel accident is of the kind that the patient's condition judged on medical grounds makes it necessary to return to Finland.

The compelling nature of the reason related to either illness of accident is assessed purely on medical grounds.

With reference to property damage, a reason is considered compelling if the insured person's presence is required at the site of the loss.

Travel interruption expenses are also reimbursed if the insured has to return from the final travel destination to Finland prematurely because

- the insured person's next of kin in Finland unexpectedly and suddenly falls ill, has a serious accident or dies
- the insured person's travelling companion's next of kin in Finland unexpectedly and suddenly falls ill, has a serious accident or dies.

Expenses will be reimbursed only if the condition of the close relative in Finland is life-threatening.

It may also have been separately agreed upon and so entered in the insurance policy that coverage is extended to include travel interruption in domestic travel on similar grounds.

By next of kin we refer to a close relative of the insured person, the insured person's partner or a close relative of the insured person's partner. However, any cousins or more distant relatives are not considered next of kin. 'Partner' refers to a person to whom the insured person is married or with whom the insured person is in a civil partnership or cohabits with.

By travelling companion we refer to up to two persons in addition to the insured person or a family with which the insured person has jointly made the travel reservations and gone for a trip together.

9.2.2 Events not covered from Travel Interruption Cover

Travel interruption is not compensated if the reason for any interruption has been known before the journey began.

9.3 Coverable expenses

9.3.1 Expenses coverable from basic coverage

If a journey is interrupted, we will compensate expenses you have paid before the reason for the interruption became apparent.

We cover the following expenses due to travel interruption:

- separately paid services and trips at the destination that remained unused due to the interruption. If these expenses are already included in the compensation to the insured person or his/her guardian for the entire journey on the basis of a subsequent provision herein, they will not be reimbursed on the basis of this provision.
- separately paid trips and travel tickets outside the destination where the interruption occurred or from there onwards, where these remained unused due to the interruption, and the insured person's share of such unused accommodation or other services. If the travel is interrupted due to an illness of a travelling companion, the insured person is compensated only if the person who fell ill is under 15 years of age and the insured person is his/her guardian or the illness results in an untimely return from the journey. If these expenses are already included in the compensation to the insured person or his/her guardian for the entire journey described in the next item, they will not be reimbursed on the basis of this item.

- the price of the entire journey if the insured person loses at least 70% of his/her travel days owing to hospitalisation or returning home prematurely. Indemnity for days lost on account of hospital treatment is only paid to the insured who is hospitalised. If the insured who is hospitalised is under 15 years of age and the treatment of the travel illness or injury requires, on the order of a physician, the guardian's assistance, the guardian is correspondingly indemnified for travel days lost.
- necessary and reasonable extra travel and accommodation costs to the insured during the journey when the insured is compelled to interrupt the journey owing to major damage to the insured's property in Finland and said damage urgently requires the presence of the insured at the site of the loss. Substantial property damage does not, however, include loss of or damage to money, payment instruments or vehicles. By extra travel and accommodation costs we refer to costs caused to the insured owing to journey interruption in addition to those paid in advance.
- reasonable expenses approved by the insurance company for a new journey to the same destination if such a journey takes place during the validity of the insurance and is necessary because of work or continuing studies in an educational institution.

Any unused services or accommodation, or trips and journeys you will not be participating in must be cancelled with the tour organiser or service provider as soon as the reason for the interruption becomes apparent. If they are not cancelled, Travel Interruption Cover only compensates the part of the insured person's expenses which according to the law or terms and conditions of the tour organiser or other service provider would have been the insured person's responsibility if cancellation had been done.

By services we mean separately paid rented transportation, courses, events and equivalent related to the interrupted journey. By local trips we mean short trips in the travel destination or its immediate vicinity.

The price of the journey is considered to be previously bought travel tickets and the insured person's part of previously paid-for accommodation expenses or the price of a package tour, special package tour or package travel. Separately paid services and local trips are not included in the calculation of the journey price. A package tour is defined here as a journey which is subject to the general terms and conditions of package tours and the Package Travel Act. By special package tour we mean a journey to which also the tour organiser's special conditions are applied. Package travel refers to a package to which the Act on package travel and linked travel arrangements or corresponding foreign law is applied in terms of organisation and sale.

Journey days are calculated as full 24-hour periods from the time the insured arrived at the first travel destination to the scheduled departure time of the means of transport to which the insured had already at the time of the interruption bought a ticket.

Lost journey days are calculated as full 24-hour periods from the time hospitalisation began or from the journey interruption to the time when hospitalisation ended, or in the case of travel interruption, to the scheduled departure time of the means of transport for which the insured had already, at the time of the interruption, bought a ticket. If the last period is over 12 hours but less than 24 hours, this period as also factored in when calculating lost journey days.

If the insured has not already purchased a ticket to leave the destination when the reason for the interruption becomes apparent, the price of the entire journey will not be compensated on the basis of lost travel journeys.

9.3.2 Expenses coverable from comprehensive coverage

If a journey is interrupted, we will compensate expenses you have paid before the reason for the interruption became apparent.

We cover the following expenses due to travel interruption:

- separately paid services and trips at the destination that remained unused due to the interruption. If these expenses are already included in the compensation to the insured person or his/her guardian for the entire journey on the basis of a subsequent provision herein, they will not be reimbursed on the basis of this provision.
- separately paid trips and travel tickets outside the destination where the interruption occurred or from there onwards, where these remained unused due to the interruption, and the insured person's share of such unused accommodation or other services. If the travel is interrupted due to an illness of a travelling companion, the insured person is compensated only if the person who fell ill is under 15 years of age and the insured person is his/her guardian or the illness results in an untimely return from the journey. If these expenses are already included in the compensation to the insured person or his/her guardian for the entire journey described in the next item, they will not be reimbursed on the basis of this item.
- the price of the entire journey if the insured person loses at least 40% of his/her travel days owing to hospitalisation or returning home prematurely. Indemnity for days lost on account of hospital treatment is only paid to the insured who is hospitalised. If the insured who is hospitalised is under 15 years of age and the treatment of the travel illness or travel injury requires, on the order of a physician, the guardian's assistance, the guardian is correspondingly indemnified for travel days lost.
- necessary and reasonable extra travel and accommodation costs to the insured during the journey when the insured is compelled to interrupt the journey owing to major damage to the insured's property in Finland and said damage urgently requires the presence of the insured at the site of the loss. Substantial property damage does not, however, include loss of or damage to money, payment instruments or vehicles. By extra travel and accommodation costs we refer to costs caused to the insured owing to journey interruption in addition to those paid in advance.

- reasonable expenses approved by the insurance company for a new journey to the same destination if such a journey takes place during the validity of the insurance and is necessary because of work or continuing studies in an educational institution.

Any unused services or accommodation, or trips and journeys you will not be participating in must be cancelled with the tour organiser or service provider as soon as the reason for the interruption becomes apparent. If they are not cancelled, Travel Interruption Cover only compensates the part of the insured person's expenses which according to the law or terms and conditions of the tour organiser or other service provider would have been the insured person's responsibility if cancellation had been done.

By services we mean separately paid rented transportation, courses, events and equivalent related to the interrupted journey. By local trips we mean short trips in the travel destination or its immediate vicinity.

The price of the journey is considered to be previously bought travel tickets and the insured person's part of previously paid-for accommodation expenses or the price of a package tour, special package tour or package travel. Separately paid services and local trips are not included in the calculation of the journey price. A package tour is defined here as a journey which is subject to the general terms and conditions of package tours and the Package Travel Act. By special package tour we mean a journey to which also the tour organiser's special conditions are applied. Package travel refers to a package to which the Act on package travel and linked travel arrangements or corresponding foreign law is applied in terms of organisation and sale.

Journey days are calculated as full 24-hour periods from the time the insured arrived at the first travel destination to the scheduled departure time of the means of transport to which the insured had already at the time of the interruption bought a ticket.

Lost journey days are calculated as full 24-hour periods from the time hospitalisation began or the journey or package travel was interrupted, to the time when hospitalisation ended, or in the case of travel interruption, to the scheduled departure time of the means of transport for which the insured had already, at the time of the interruption, bought a ticket. If the last period is over 12 hours but less than 24 hours, this period as also factored in when calculating lost journey days.

If the insured has not already purchased a ticket to leave the destination when the reason for the interruption becomes apparent, the price of the entire journey will not be compensated on the basis of lost travel journeys.

9.4 Expenses which are not covered

Coverable expenses do not include

- extra travel and accommodation costs, unless the reason for the travel interruption is major damage to the insured person's property in Finland, and said damage urgently requires the presence of the insured at the site of the loss. Substantial property damage does not, however, include loss of or damage to money, payment instruments or vehicles. By extra travel and accommodation costs we refer to costs caused to the insured owing to journey interruption in addition to those paid in advance.
- the costs of transporting a car, other means of transport or luggage back to Finland
- loss of bonus points, RCI points or equivalent
- loss of income or indirect costs, such as those incurred for meals, parking or similar
- expenses that have already been reimbursed or for which compensation has been sought from another cover or insurance policy.

9.5 Filing a claim

9.5.1 Itinerary and documentation on event causing interruption

Claimants must submit to the insurance company written documentation on the itinerary, illness, accident or death that caused the interruption, or major damage to property in Finland, and any expenses and losses that were incurred. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

9.5.2 Receipts

Claimants must first pay the costs themselves and subsequently claim compensation from those responsible for them under the law or tour operator's or other service provider's terms and conditions. If expenses have not been reimbursed by virtue of law or according to the tour operator or other service provider, the claimant must submit, upon request, original receipts or equivalent documentation of them to the insurance company.

9.5.3 Loss investigation costs

Fees charged by doctors for medical statements are not reimbursed as loss investigation costs. Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

9.6 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

10 Delayed Departure Cover

10.1 Key contents of insurance cover

The insurance provides cover for alternative routes, when the insured must wait for public transportation for a reason referred to in the insurance terms and conditions.

Compensation is only paid if the reason for waiting has become apparent and the expense for the alternative route occurred while the insurance was valid.

Moreover, for an event to be indemnifiable, it must occur within a certain period of time after the start of the covered trip as specified in the policy document. Only those expenses are reimbursed that were incurred from the first day of the journey for a period entered as the insurance policy's validity in the policy.

Expenses are only covered insofar as they are not or would not have been coverable under some Act or by a tour operator, travel agent, hotel, transport company or equivalent.

Expenses are usually reimbursed up to a maximum total of a sum entered in the insurance policy per incident that caused the delay. Costs are reimbursed according to the maximum amount of compensation that was valid when the reason for the delay became known.

We will subtract the deductible per insurance event that was entered in the insurance policy and valid when the reason for the delay became apparent.

10.2 Coverable events and exclusions to them

Expenses are covered if the means of public transport which the insured person should be using and for which s/he had already bought a ticket does not depart in at least four hours or at all. Expenses are covered if the delay occurs because a means of public transport cannot be used owing to poor weather, natural disaster, technical fault, criminal act or action taken by the authorities.

The condition for any compensation to be paid is that the insured submits to the insurance company the reasons for the delay provided by the airline, transport company, tour organiser or authority.

Expenses are not reimbursed if the reason for waiting or delay was a strike or bankruptcy.

10.3 Coverable expenses

Coverable expenses include the insured person's reasonable and necessary additional travel and accommodation costs that are necessary to continue the journey to the destination or back to the final destination in Finland, according to the original itinerary.

Extra travel and accommodation costs refer to costs incurred by the insured in addition to those paid in advance.

10.4 Expenses which are not covered

Coverable expenses do not include

- bonus or other points used to cover extra travel expenses
- loss of income or indirect costs, such as those incurred for meals, parking or similar
- expenses that have already been reimbursed or for which compensation has been sought from another cover or insurance policy.

10.5 Filing a claim

10.5.1 Documentation concerning journey and waiting

Claimants must submit to the insurance company written documentation on the itinerary, delayed vehicle, the reason for its delay and the extra costs. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

10.5.2 Receipts

Claimants must first pay the costs themselves and subsequently claim compensation from those responsible for them under the law, or tour operator's or other service provider's terms and conditions. If expenses have not been reimbursed by virtue of law or according to the tour operator or other service provider, the claimant must submit upon request original receipts or equivalent documentation of them to the insurance company.

10.5.3 Loss investigation costs

Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

10.6 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

11 Missed Departure Cover

11.1 Key contents of insurance cover

Coverage is provided against missed departure for a flight, boat, train or bus journey in the cases referred to in the insurance terms and conditions.

Compensation is only paid if the reason for the delay has become apparent and the expense caused by it occurred while the insurance was valid.

Moreover, for an event to be indemnifiable, it must occur within a certain period of time after the start of the covered trip as specified in the policy document. Only those expenses are reimbursed that were incurred from the first day of the journey for a period entered as the insurance policy's validity in the policy.

Expenses are only covered insofar as they are not or would not have been coverable under some Act or by a tour operator, travel agent, hotel, transport company or equivalent.

Expenses are usually reimbursed up to a maximum total of a sum entered in the insurance policy per incident that caused the departure to be missed. Costs are reimbursed according to the maximum amount of compensation that was valid when the reason for the missed departure became known.

We will subtract the deductible per insurance event that was entered in the insurance policy and valid when the reason for the missed departure became apparent.

11.2 Coverable events and exclusions to them

Missed departure is compensated if the insured fails to arrive at the departure point for a flight or a boat, train or bus journey or the departure point for a connecting flight or a boat, train or bus journey to a foreign destination because

- a public conveyance on which the insured intended to travel or was travelling to the above departure point is delayed due to weather, natural catastrophe, technical malfunction, criminal act, road accident or action by an authority, or
- a motor vehicle which the insured intended to use or which he was actually using to get to the above departure point is delayed due to weather, natural catastrophe, technical malfunction, criminal act against the vehicle, road accident or action by an authority.

Compensation is payable provided that

- the insured has already bought a ticket for the vehicle s/he misses
- the insured submits written documentation provided by the airline, transport company, tour organiser, authority or vehicle repair shop on the reason for the missed departure to the insurance company.

Expenses are not reimbursed if the reason for the missed departure was a strike or bankruptcy.

11.3 Coverable expenses

The following are compensated from Missed Departure Cover:

- insured person's reasonable and necessary additional travel and accommodation costs that are necessary to continue the journey to the destination or back to Finland to the final destination, according to the original itinerary
- travel services at the destination bought separately in advance that were not used because the insured person missed his/her departure
- the share of lost travel days of the journey price owing to missed departure, or the entire price of the journey if, owing to the missed departure, it is no longer possible to take the journey.

Extra travel and accommodation costs refer to costs incurred by the insured in addition to those paid in advance.

By travel services we mean vehicle rents, fees for local trips and courses, and event entrance fees related to the journey in question which the insured has paid in advance.

The price of the journey is considered to be previously bought travel tickets and the insured person's part of previously paid-for accommodation expenses or the price of a package tour, special package tour or package travel. Separately paid travel services are not included in the calculation of the journey price. A package tour is defined here as a journey which is subject to the general terms and conditions of package tours and the Package Travel Act. By special package tour we mean a journey to which also the tour organiser's special conditions are applied. Package travel refers to a package to which the Act on package travel and linked travel arrangements or corresponding foreign law is applied in terms of organisation and sale.

Journey days are calculated as full 24-hour periods from the time the insured should have arrived at the travel destination according to the original itinerary to the scheduled departure time of the latest means of transport to which the insured had already bought a ticket.

Lost travel days are calculated as full 24-hour periods from the time when the insured should have arrived at the destination according to the original itinerary to the time when the he actually arrived there.

If the insured has not already bought a ticket to leave the destination when the reason for the missed departure becomes apparent, the share of lost travel days of the journey price will not be compensated.

11.4 Expenses which are not covered

Coverable expenses do not include

- bonus or other points used to cover extra travel expenses
- loss of income or indirect costs, such as those incurred for meals, parking or similar
- lost travel days if the insured receives compensation for the price of the entire journey from Travel Interruption Cover
- expenses that have already been reimbursed or for which compensation has been sought from another cover or insurance policy.

11.5 Filing a claim

11.5.1 Documentation on the itinerary and missed departure

The claimant must submit to the insurance company written documentation on the itinerary, missed departure, reason for missed departure and any expenses and losses that resulted. This is done by filing a loss report with the insurance company. If requested, additional information must be provided to the insurance company in order to settle the claim.

11.5.2 Receipts

Claimants must first pay the costs themselves and subsequently claim compensation from those responsible for them under the law, or tour operator's or other service provider's terms and conditions. If expenses have not been reimbursed by virtue of law or according to the tour operator or other service provider, the claimant must submit upon request original receipts or equivalent documentation of them to the insurance company.

11.5.3 Loss investigation costs

Claimants must acquire said documentation and information and submit it to the insurance company at their own expense.

11.6 Other applicable terms and conditions

The common provisions of all travel insurance policies and Pohjola Traveller's Insurance are applied to this cover.

GENERAL TERMS OF CONTRACT

The General Contract Terms and Conditions apply to all the types of insurance included in the insurance contract.

The General Terms of Contract contain the relevant provisions of the Insurance Contracts Act (543/94). The symbol § in brackets refers to the relevant sections of the Insurance Contracts Act in which the matters in question are dealt with. The insurance contract is also subject to certain provisions of the Insurance Contracts Act not appearing from these General Contract Terms and Conditions. Insofar as these General Contract Terms and Conditions differ from the optional provisions of the Insurance Contracts Act, these General Contract Terms and Conditions shall apply to the insurance contract.

1 Concepts (§§2 and 6)

The policyholder is the party who has concluded an insurance contract with the insurer.

The insurer in terms of life insurance is OP Life Assurance Company Ltd. For any other insurance, the insurer is Pohjola Insurance Ltd. In these terms and conditions, the insurer is referred to as 'the insurance company'. The insurers under the contract are stated in the insurance policy.

The **insured person** is the party who is the object of insurance of the person or for whose benefit non-life insurance is valid.

The **insurance period** is the agreed period recorded in the policy document during which the insurance is valid. The insurance contract continues for one agreed insurance period at a time, unless either contracting party gives notice of termination.

The **premium period** is the period for which a premium is paid at regular intervals as agreed.

The **insurance event** is an event for which compensation is paid under the insurance.

Non-life insurance is a policy taken out to cover a loss incurred due to material damage, an obligation to pay damages, or other financial loss.

Insurance of the person, or personal insurance, is insurance by which a natural person is covered.

Group insurance is insurance under which those insured are members of a group as defined in the insurance contract, and the premium is paid in full by its policyholder.

2 Disclosure of information prior to concluding an insurance contract

2.1 Policyholder's and insured person's obligation to disclose information (§22)

Prior to the insurance being granted, the policyholder and the insured must provide full and correct answers to all questions presented by the insurance company which may affect the assessment of the insurance company's liability. During the validity of the insurance period, the policyholder and the insured must also correct, without undue delay, any information provided by the insured to the insurance company which the insured has found to be incorrect or insufficient.

2.2 Failure to disclose information under non-life insurance (§§23 and 34)

If the policyholder or insured person has acted fraudulently when fulfilling the obligation to disclose information, the insurance contract shall not be binding on the insurance company. The insurance company has the right to withhold all premiums paid, even if the insurance is annulled.

If the policyholder or insured person has wilfully or through negligence which cannot be deemed minor failed in his/her obligation to disclose information under non-life insurance, compensation payable under the insurance can be reduced or disallowed. The effect of the erroneous or deficient information given by the policyholder or the insured person on bringing about the loss or damage will be taken into account when reduction or disallowance is being considered. In addition, the policyholder's and the insured person's intent or type of negligence as well as other circumstances will be taken into account.

If, due to incorrect or insufficient information provided by the policyholder or the insured person, the agreed premium is smaller than it would have been had the insurance company been given the correct and full information, the insurance company, when reducing the amount of compensation, takes account of the ratio of the agreed premium to the premium that would have been charged had the information provided been correct and full. If, however, the information provided differs only slightly from the correct and full information, the insurance company is not entitled to reduce the compensation.

For example, in motor vehicle insurance, the actual user of the object of insurance must be reported as the vehicle holder; any wrong person (so-called ostensible owner or holder) must not be reported as the vehicle owner or holder.

2.3 Failure to disclose information under insurance of the person (§24)

If the policyholder or insured person has acted fraudulently when fulfilling the obligation to disclose information, the insurance contract shall not be binding on the insurance company. The insurance company has the right to withhold all premiums paid, even if the insurance is annulled.

If the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed in their obligation to disclose information under insurance of the person, and the insurance company would have refused to grant the insurance altogether had the full and correct information been provided, the insurance company is free from liability. If the insurance company had granted the insurance only against a higher premium or otherwise on terms other than those agreed, the insurance company's liability is restricted to what corresponds to the agreed premium or the terms on which the insurance would have been granted.

If the above-mentioned consequences of failure to disclose information leads to a result that is clearly unreasonable from the point of view of the policyholder or other party entitled to compensation, they may be adjusted.

3 Beginning of the insurance company's liability and validity of the insurance contract

3.1 Beginning of the insurance company's liability (§11)

If the insurance company has not agreed on any other date individually with the policyholder, the insurance company's liability will commence from the time when the insurance company or the policyholder has submitted or sent an affirmative reply to the offer/bid of the other contracting party.

Payment of the premium for the insurance period is a precondition for commencement of the insurance company's liability

- always in the case of a Sports Cover insurance or a fixed-term travel insurance
- when the insurance company has set the payment of the premium for the first insurance period as a precondition before continuous travel insurance can enter into force, or
- if there are special reasons, for instance, because of the policyholder's earlier default of payment.

The insurance bill contains mention to this effect.

3.2 Grounds for granting insurance

The insurance premium and other terms of contract are determined in accordance with the policy anniversary. If another insurance is added to the contract, the premium and other contract terms are determined in accordance with the starting date of the added insurance.

Under insurance of the person, the insured person's state of health is assessed and his/her age calculated on the basis of his/her state of health and age at the time of submitting the insurance application. The insurance company will not reject an application for personal insurance on the grounds that an insurance event has occurred or that the state of health of the person for whom the application is made deteriorated after the application documents were submitted or sent to the insurance company.

3.3 Validity of the insurance contract (§§16 and 17)

After the first insurance period, a non-life insurance contract is valid for one agreed insurance period at a time, unless the policyholder or the insurance company terminates the contract.

After the first premium period, an insurance contract regarding insurance of the person is valid for one agreed premium period at a time, unless the policyholder or the insurance company terminates the contract. However, in the case of life insurance and disability insurance, the insurance company does not have the right to give notice if the terms and conditions of Insurance no longer sold are applied to the said policies.

The insurance contract may also terminate for other reasons referred to in clauses 4.2 and 14 below.

A fixed-term insurance contract is valid for the agreed insurance period. The insurance can, however, be terminated during the insurance period on grounds specified below in clauses 4.2 and 14.

In fixed-term travel insurance, if the journey back to the insured person's country of residence is delayed for reasons beyond the insured person's control, the validity period of the insurance will be extended by 48 hours.

The validity of Crisis Cover, which can be taken out in connection with motor liability insurance, does not extend beyond that of the motor liability insurance which is the basic component of the insurance package.

4 Insurance premium

4.1 Premium payment (§38)

The insurance premium must be paid within one month of the date on which the insurance company sent the premium bill to the policyholder or notified the policyholder of the premium due date.

The premiums of the individual insurance policies included in the same insurance contract are combined into a single premium to be invoiced in one or several instalments as agreed. If a premium arising from a change in the insurance contract is not combined with the earlier agreed instalments, this premium will be invoiced separately. The insurance premium paid for the insurance contract is divided amongst all cover types included in the contract in proportion to the relationship between the payment and the invoice, so that all continuous insurance types are valid until the same date.

If a payment by the policyholder is not sufficient to cover all the insurance company's insurance premium receivables, the policyholder has the right to decide which of the outstanding premiums the money is to be used for. However, the policyholder's payment will primarily apply to the insurance contract in accordance with the reference data based on the paid bill, unless the policyholder has specifically ordered otherwise in writing in connection with the payment.

4.2 Delayed premium (§39)

If the policyholder has neglected to pay the premium in part or in full by the due date as referred to under clause 4.1, the insurance company has the right to terminate the entire insurance contract 14 days after sending a notice of termination. Such termination may also be carried out by one insurance company referred to in clause 1 on behalf of another.

However, if the policyholder pays the outstanding premium in full before the end of the notice period, the insurance contract will not be terminated at the end of the notice period. The insurance company will state this option in its notice of termination.

If the delay of payment is caused by the policyholder's financial difficulties resulting from illness, unemployment or other special reason primarily beyond the policyholder's control, then despite the notice given, the insurance will not expire until 14 days after the obstacle in question has ceased to exist. The contract will, however, expire three months from the end of the notice period, at the latest. The notice of termination will state this option concerning continuation of the insurance for a fixed period. The policyholder must notify the insurance company in writing of the financial difficulties referred hereto during the notice period at the latest.

If the premium is not paid by the due date referred to under clause 4.1 above, penalty interest must be paid for the period of delay in accordance with the Interest Act.

The insurance company is entitled to compensation for costs incurred due to collection of insurance premiums under the Debt Collection Act. If the insurance company

has to collect an unpaid insurance premium through legal action, it is also entitled to being recompensed for the statutory fees and charges incurred due to legal proceedings.

The insurance company may transfer outstanding amounts for collection by a third party.

4.3 Minimum insurance premium

The premium for any insurance period, including tax, is at least the minimum amount separately confirmed in the insurance policy or product guide for each insurance line.

The insurance period refers to a period of up to one year during which the insurance is valid at a time under the contract.

4.4 Returning premium at the termination of a contract (§45)

If the insurance terminates before the date agreed, the insurance company is entitled only to the premium for the period during which it was liable. The rest of the premium paid will be returned to the policyholder.

When determining the amount of returnable premium, the validity is calculated in days according to the insurance period to which the premium pertains.

The annual premium for policies with seasonal rating is, however, divided between months relative to risk, and upon the expiry of the policy the remainder of the previously paid premium for the insurance period will be refunded.

However, the premium is not returnable in cases stated below in this clause or if the policyholder or the insured person has acted fraudulently in the circumstances referred to in clauses 2.2 or 2.3 above. The premium is not returned separately if the returnable sum is smaller than the sum in euros specified in the Insurance Contracts Act.

In insurance policies where the risk of loss/damage or the policy's treatment expenses are highest at the outset of the policy's validity; however, the insurance premium for the first insurance period or premium period is always the minimum premium specified in the policy document or product guide. The minimum premium corresponding to the policy's treatment expenses may also be charged for periods following the first insurance period or premium period.

4.5 Setoff against premiums to be returned

The insurance company may deduct any outstanding premiums overdue and other overdue receivables from the premium to be returned. Furthermore, as regards Extrasure insurance policies, a setoff can be made on behalf of all of the insurance companies that may be acting as insurers in the Extrasure contract.

5 Policyholder's obligation to disclose information about any increase in risk (sections 26, 27 and 34)

5.1 Increase in risk under non-life insurance

The policyholder must notify the insurance company of any essential change, during the insurance period, in the circumstances stated at the time of concluding the insurance contract or in the state of affairs specified in the policy document, which has increased the risk of loss or damage, and which the insurer cannot be deemed to have taken into account when concluding the contract. The policyholder must notify the insurance company of any such changes no later than one month of receipt of the annual bulletin following such a change. The insurance company will remind the policyholder of this obligation in the annual bulletin.

Changes resulting in increased risk may include repairs, alterations or extensions of the insured object, its altered use, surrender to the use of others than those insured for a continuous period exceeding three months, or transfer to other than homelike premises.

As regards motor vehicle insurance, changes resulting in increased risk can be, for instance, changing the use of a motor vehicle so that its use requires a permit or so that it can be rented, changing the domicile of a motor vehicle or use of the vehicle mainly abroad, or increasing the power of a vehicle's engine or exchanging the engine for a more powerful one.

As regards professional liability insurance, changes resulting in increased risk may include a change in the type or extent of operations.

As regards horse insurance, changes resulting in increased risk may include entering a horse originally designated for breeding purposes into races.

As regards boat insurance, changes resulting in increased risk may include changing the use of a boat so that it can be used professionally or rented, changing the boat's structure for competitive use or increasing the boat's motor power by over 20% of the amount specified in the insurance contract.

If the holder of a non-life insurance policy has wilfully or through negligence which cannot be deemed minor failed to notify the insurance company of the increased risk, any compensation may be reduced or disallowed. The effect of the changed, risk-increasing circumstance on the occurrence of the loss or damage is taken into account when considering whether to reduce or disallow the compensation. The policyholder's intent or the type of negligence and any other circumstances will also be taken into account.

If, due to incorrect or insufficient information provided by the policyholder or the insured person, the agreed premium is smaller than it would have been had the insurance company been given the correct and full information, the insurance company, when reducing the amount of compensation, takes account of the ratio of the agreed premium to the premium that would have been charged had the information provided been correct and full. If, however, the information provided differs only slightly from the correct and full information, the insurance company is not entitled to reduce the compensation.

5.2 Increase in risk under insurance of the person

The policyholder must notify the insurance company of any changes in factors increasing risk that were reported when the insurance contract was concluded and that are rele-

vant in terms of assessment of the insurance company's liability, such as changes in profession/occupation, leisure time activities or place of residence, or the termination of any other insurance cover. A change resulting in increased risk may be, for instance, residence abroad of the insured person for over a year on a continuous basis. The policyholder must notify the insurance company of any such changes no later than one month of receipt of the annual bulletin following such a change. Changes in the person's state of health do not have to be reported. The insurance company reminds policyholders in the annual bulletin of their disclosure obligation.

If, in the case of insurance of the person, the policyholder has wilfully or through negligence which cannot be deemed minor failed to notify the insurance company of increased risk as mentioned above, and the insurance company would not, as a result of the changed circumstances, have kept the insurance in force, the insurance company is released from liability. If, however, the insurance company had continued the insurance but only for a higher premium or on other terms, the insurance company's liability is limited to that which corresponds to the insurance premium or the terms on which the insurance would have been continued.

If the above-mentioned consequences of failure to disclose information lead to a result that is clearly unreasonable from the point of view of the policyholder or other party entitled to compensation, they may be adjusted.

6 Obligation to prevent and limit loss or damage under non-life insurance

6.1 Obligation to observe safety regulations (sections 31 and 34)

The insured person must observe the safety regulations recorded in the insurance policy, the insurance terms and conditions or otherwise provided in writing. If the insured has wilfully or through negligence which cannot be deemed minor failed to observe the safety regulations, the insurance company may reduce or disallow any compensation payable to them. The effect of the failure to observe the safety regulations on the occurrence of the loss or damage is taken into account when considering whether to reduce or disallow compensation. The insured's intent or type of negligence and any other circumstances will also be taken into account.

6.2 Obligation to prevent and limit loss or damage (salvage obligation) (§§32, 34 and 61)

In the case of an insurance event or the immediate threat of one, the insured person must, in accordance with their ability, take the necessary action to prevent or limit the loss or damage. If the loss or damage is caused by a third party, the insured must take the necessary action to uphold the insurance company's right vis-à-vis the liable party. The insured must, for instance, attempt to establish the identity of the tort-feasor. If the loss or damage resulted from a punishable act, the insured person must, without delay, report it to the police and sue the offenders if the insurance company's interest so requires. The insured person must, in other respects, too, observe all instructions given by the insurance company aimed at preventing and mitigating loss or damage.

With respect to motor vehicle insurance, in the case of loss or damage due to fire, theft, vandalism or a collision with some other deer than a reindeer, the insured must immediately report to the local police. If a motor vehicle is stolen or permanently lost abroad, a notification must also be made to the Finnish police. If the insurance company so requires, a police investigation must be held at other times, too, and the related investigation report must be submitted to the insurance company.

Should the keys to the vehicle or any similar device needed for starting the vehicle, such as key cards, be lost, the immobiliser must immediately be coded so that the lost keys cannot be used for starting the vehicle. Before coding, the vehicle must have been locked with a mechanical locking device which cannot be opened with the lost key.

The insurance company will indemnify for reasonable expenses incurred due to fulfilling the above duty of salvage even if the sum insured would thus be exceeded.

If the insured person has wilfully or through negligence which cannot be deemed minor failed to observe the duty of salvage referred to above, the insurance company may reduce or disallow the compensation payable to them. The effect of the failure to observe the duty of salvage on the occurrence of the loss or damage is taken into account when considering whether to reduce or disallow the compensation. The insured's intent or type of negligence and any other circumstances will also be taken into account.

6.3 Failure to observe the safety regulations and the salvage obligation in liability insurance (§§31 and 32)

Under liability insurance, negligence on the part of the insured person will not lead to compensation being reduced or disallowed.

However, if the insured person has wilfully or through gross negligence failed to observe the safety regulations or the duty of salvage, or if the insured person's use of alcohol or other intoxicant has contributed to the negligence, compensation may be reduced or disallowed.

If, through gross negligence, the insured has failed to observe the safety regulations or duty of salvage, or if the insured person's use of alcohol or other intoxicant has contributed to negligence, the insurance company will nevertheless pay from the liability insurance that part of the compensation which the natural person who has suffered the loss or damage has been unable to collect because of the insured person's state of insolvency as authenticated by distraint or bankruptcy.

7 Causing an insurance event

7.1 Non-life insurance (§§30 and 34)

The insurance company is released from liability to the insured if the insured person has wilfully caused the insurance event.

If the insured has caused an insurance event through gross negligence or if the insured person's use of alcohol or some

other intoxicant has contributed to the insurance event, the compensation payable may be reduced or disallowed.

The effect of the insured's action on the occurrence of the loss or damage is also taken into account in considering whether the compensation is to be reduced or disallowed in the above-mentioned cases. The insured person's intent or the type of negligence and other circumstances will also be taken into account.

As regards motor vehicle insurance, if the insured has caused an insurance event while driving a motor vehicle with a blood alcohol content of at least 1.2 per mille, or a minimum of 0.53 mg of alcohol per litre of exhaled air while driving or immediately after it, or if the insured's ability to perform the required tasks was considerably diminished due to the influence of an intoxicant other than alcohol or due to the combined effect of alcohol and another intoxicant, compensation is paid only to the extent that any other circumstances have contributed to the loss or damage.

If, at the time of loss, the insured was driving the vehicle with a blood alcohol content of at least 0.5 per mille, or a minimum of 0.22 mg of alcohol per litre of exhaled air while driving the vehicle or immediately after it, or if the ability of the insured to perform the required tasks was diminished due either to the influence of an intoxicant other than alcohol or the combined effect of alcohol and another intoxicant, compensation shall be reduced in proportion to the extent of the loss attributable to the insured.

As regards liability insurance, if the insured person has caused an insurance event through gross negligence, or if the insured person's use of alcohol or other intoxicant has contributed to the insurance event, the insurance company will nevertheless pay that part of the compensation which the natural person who has suffered the loss or damage has been unable to collect because of the insured person's state of insolvency, as authenticated by distraint or bankruptcy.

7.2 Insurance of the person (§§28 and 29)

The insurance company is released from liability to any insured person who has wilfully caused an insurance event.

If the insured has caused the insurance event through gross negligence, the insurance company's liability may be reduced, depending on what is deemed reasonable in the circumstances.

If a person entitled to compensation or benefit other than the insured has wilfully caused the insurance event, the insurance company is released from liability to such party. If such a person has caused the insurance event through gross negligence or he/she was at an age or in a state of mind which meant that he/she could not be sentenced for a crime, the compensation or part of the compensation may be paid to him/her, but only when this is deemed reasonable considering the circumstances in which the insurance event was caused.

If the insured has died, the other parties entitled to compensation are paid that part of the compensation which is not paid to the person(s) who caused the insurance event.

8 Identification with another person under non-life insurance (§33)

The provisions set out above concerning the insured person with regard to causing an insurance event, observing the safety regulations or the duty of salvage also apply to a person

1. who, with the consent of the insured person, is responsible for a motor-driven or towed vehicle, vessel or aircraft covered by the insurance. Consent refers to permission given by the insured to drive the above-mentioned vehicle or to use it in some other way, or to consent evident from the circumstances.
2. who, jointly with the insured person, owns the insured property and uses it jointly with them, or
3. who cohabits with the insured person and uses the insured property jointly with them.

The conditions stated above concerning the insured with regard to observing the safety regulations also apply to persons, on the basis of their employment or official post with the policyholder, who are responsible for supervising the observance of such regulations.

9 Beneficiary clause under insurance of the person

9.1 Beneficiary

The policyholder has the right to name a person (beneficiary) who is entitled to compensation instead of the policyholder or the insured person. The policyholder may change or cancel the beneficiary clause if the insurance event to which the clause is intended to be applied has not occurred.

If the beneficiary clause is valid, the benefit payable due to the death of the insured person is not part of the insured person's estate. The benefit is part of the insured person's death estate when there is no beneficiary clause and the benefit is not, in the terms and conditions of the insurance, set out to be payable to the policyholder.

9.2 Form of the beneficiary clause

A beneficiary clause, its cancellation or amendment is null and void unless it has been submitted to the insurance company in writing.

9.3 Form of the beneficiary clause under group insurance

The insurance company and the policyholder agree on the beneficiary clause in the group insurance contract.

The policyholder may change the beneficiary if the right to do this has been agreed in the group insurance contract.

If the beneficiary clause is valid, the benefit payable due to the death of the insured person is not part of the insured person's estate. The benefit is part of the insured person's death estate if there is no beneficiary clause, and if the benefit is not payable to the policyholder under the insurance terms and conditions.

10 Claims settlement procedure

10.1 Obligations of the claimant (§§69 and 72)

The claimant shall immediately notify the insurance company of the loss event. All crimes must be reported to the local police without delay.

The claimant must provide the insurance company with documents and information necessary for the assessment of the insurance company's liability. These include documents and information which confirm whether an insurance event occurred, the extent of the loss or damage and who is to be indemnified, who was driving the motor vehicle and whether alcohol or other intoxicants contributed to the occurrence of the insurance event.

The claimants shall acquire and submit to the insurance company said documentation and information at their own cost, unless otherwise agreed. The claimant shall keep any documents and information for at least six months from submitting a claim for compensation and supply them to the insurance company upon request.

For instance, the insured must not, by leaving the scene of the accident, through some other action which prevents the investigation or by consuming alcohol after the loss or damage, impede or prevent the disclosure of a fact which would be significant to the assessment of the insurance event and the liability of the insurance company.

Before any repairs, the insurance company must be given the opportunity to inspect the damaged property in order to establish the cause of damage and whether the damage is coverable under the insurance. If repairs have been initiated without giving the insurance company the opportunity to inspect the damage, the repair work must be documented by, for example, taking photos and keeping any damaged parts. A damaged object must not be disposed of without special reason.

The insurance company is not required to pay compensation before it has received the above documentation.

If the claimant has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability, their compensation may be reduced or disallowed, depending on what is reasonable in the circumstances.

Insurance companies share a non-life insurance information system which can be used in processing claims to check claims submitted to different companies. After loss or damage, the insurance company also has the right to investigate the fault and driving style data recorded in the vehicle information system, insofar as this is necessary for the assessment of the insurance company's liability.

10.2 Limitation on right to obtain compensation (§73)

A claim for compensation must be presented to the insurance company within 12 months of the date when the claimant became aware of the insurance and was informed of the insurance event and the damaging consequences of that event. A claim for compensation must in any case be presented within 10 years of the date when the insurance event occurred or, in the case of insurance taken out against bodily injury or liability for damages, the damaging consequences were caused. Reporting an insurance event is comparable to presenting a claim. If the claim is not presented within the said period, the claimant loses the right to obtain compensation.

10.3 Setoff against compensation

The insurance company may deduct any outstanding premiums overdue and other outstanding overdue amounts from compensation. Furthermore, as regards Extrasure insurance policies, a setoff can be made on behalf of all of the insurance companies that may be acting as insurers in the Extrasure contract.

10.4 Persons covered by property insurance (§62)

Property insurance is valid for the benefit of the owner, the person who has purchased the property under a provision regarding reservation of title, the holder of a right of lien and a right of retention, or some other party that bears the liability for risk pertaining to the property.

10.5 Impact of sanctions on compensation

The insurance company, its subsidiary, or a partner in a network underwriting insurance locally is under no obligation to pay indemnity, damages, prevention costs or investigation and legal expenses or any other financial resources, if paying them is contrary to sanctions, other restrictive actions or legislation imposed by the Finnish government, the United Nations, the European Union, the United States of America, or the United Kingdom or their competent authorities or governing bodies.

10.6 Changes in legislation

This clause applies to policies that have commenced on or after 1 April 2022.

In the event of any change in legislation during the insurance period by which the insurance company´s liability materially increases or expands from what it was before the change, the legislation shall be applied to the insurance policy as it was at the beginning of the insurance period.

11 Lodging an appeal against a decision taken by the insurance company (sections 8, 68 and 74)

11.1 Right to correct

If a policyholder or claimant suspects that the insurance company has made a mistake in its claim settlement decision, they have the right to obtain more information about matters which have led to the decision. The insurance company will revise the decision if the new investigations give cause to do so.

11.2 FINE and the Consumer Disputes Board

The Finnish Financial Ombudsman Bureau (www.fine.fi) offers free and independent advice and assistance. FINE's Finnish Financial Ombudsman Bureau and the Finnish

Insurance Complaints Board also give dispute settlement recommendations in civil action cases. FINE does not handle a dispute pending in or already processed by the Consumer Disputes Board or the Court of Justice.

A decision made by an insurance company may also be submitted to the Consumer Disputes Board (www.kuluttajariita.fi). Before submitting a matter to the Consumer Disputes Board, consumers should first consult the Consumer Advisory Services within the Finnish Competition and Consumer Authority (www.kkv.fi/en/consumeradvice). The Consumer Disputes Board will not process any disputes that are pending or already processed at the Finnish Insurance Complaints Board or a court of law.

11.3 District court

If the policyholder or claimant is dissatisfied with the insurance company's decision, the policyholder or claimant may bring action against the insurance company.

Action against the insurance company's decision must be brought within three years of the policyholder or claimant being informed in writing about the insurance company's decision and the time limit. The right to bring action ceases once the time limit has expired.

Handling of a case by a board will interrupt the limitation period for the right to bring action.

As regards boat damage, an indemnity adjustment by the Average Adjuster in Finland must be obtained before court proceedings (Act on Indemnity Adjustments by the Average Adjuster, 10/1953).

12 The insurance company's right of recovery (section 75)

The insured person's right to claim damages from a third party which is held liable transfers to the insurance company up to the amount of compensation paid by the insurance company.

If the loss or damage was caused by a third party as a private person or as an employee, a civil servant or any other person comparable to these as referred to in chapter 3, section 1 of the Tort Liability Act, or as the owner, keeper, driver or passenger of a vehicle, the right of recovery will be transferred to the insurance company only if the person in question caused the insurance event wilfully or through gross negligence or is held liable regardless of the nature of his/her negligence.

In addition to the above, if the loss or damage was caused while driving a motor vehicle, the insurance company also has the right to reclaim the compensation it has paid owing to the loss if the driver caused the loss or damage with a blood alcohol content of at least 1.2 per mille while driving or immediately after it, or if the driver had a minimum of 0.53 mg of alcohol per litre of exhaled air, or if the driver's ability to perform the required tasks was considerably diminished due to the influence of an intoxicant other than alcohol or due to the combined effect of intoxicants.

As regards insurance of the person, the insurance company has the right of recovery vis-à-vis a third party only in the case of compensation paid for loss of property or costs incurred due to illness or accident.

If the loss or damage was caused by using a motor vehicle in traffic, an insurance company that has paid compensation under a voluntary insurance policy has the right of recourse towards the motor liability insurance company, up to the amount of compensation paid by the former.

13 Altering an insurance contract

13.1 Altering the terms of contract during the insurance period under non-life insurance (§18)

The insurance company has the right to alter the insurance premiums or other terms of contract during the insurance period to correspond to the new circumstances if

1. the policyholder or the insured has neglected the obligation to disclose information as referred to in clause 2.1 above; or
2. during the insurance period, a change as referred to in clause 5 above has occurred in the circumstances recorded in the insurance policy, or reported by the policyholder or the insured person to the insurance company at the time the contract was signed.

After being informed of said change, the insurance company will notify the policyholder without undue delay of how and from what date the premium or other terms of contract will be altered. The notification shall state that the policyholder has the right to cancel the insurance.

13.2 Altering the terms of contract during the insurance period under insurance of the person (§20)

The insurance company has the right to alter the insurance premiums or other terms of contract during the insurance period to correspond to the true or changed circumstances if

1. the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor failed to observe the obligation to disclose information as referred to in clause 2.1 above, and if the insurance company, had it been given the correct and full information, had granted the insurance only against a higher premium or otherwise on terms other than those agreed; or
2. the policyholder or the insured person has acted fraudulently in observing the obligation to disclose information as referred to in clause 2.1 above and, regardless of this, the insurance is binding on the insurance company on the basis of clause 2.3, due to the adjustment of the consequences of the failure to disclose information; or
3. during the insurance period, a change as referred to in clause 5 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would have granted the insurance only against a higher premium or on otherwise other terms, in the event that the circumstance related to the insured person would already have corresponded to the change when the insurance company granted the insurance.

After being informed of the said change, the insurance company will notify the policyholder, in writing and without undue delay, of any change in the premium or other terms. The notification shall state that the policyholder has the right to cancel the insurance.

13.3 Altering the terms of contract at the end of an insurance period under continuous non-life insurance and insurance of the person (§§19 and 20a)

Notification procedure

The insurance company has the right to alter the insurance terms and conditions, and premiums and other terms of contract at the end of the insurance period on the basis of

- new or amended legislation or a regulation issued by the authorities
- change in legal practice
- an unforeseeable change in circumstances (e.g. an international crisis, exceptional natural event, catastrophe)
- change in claims expenditure or cost levels, or change in the ratio between indemnities and insurance premiums
- change in a factor or circumstance which, in the view of the insurance company, has an impact on the amount of insurance premium and the risk of loss or damage. Such may include the age or domicile of the policyholder, the insured person or the owner or keeper of the object of insurance; the age, location, properties, place of insurance, claims history or claims development of the object of insurance or part thereof.

The insurance company also has the right to change the insurance premium by defining various premium bases in accordance with risks of loss or damage.

However, as regards insurance of the person, the insurance terms and conditions or premiums may not be changed on the grounds that the state of health of the insured person has deteriorated since the time the policy was taken out or that an insurance event has occurred.

Under life insurance, the insurance company has the right to alter the insurance terms and conditions, premiums and other terms of contract at the end of the premium period for the following special reasons:

- general incidence of loss or
- change in interest rates provided that the content of the insurance contract does not change substantially compared with the original contract.

The insurance company also has the right to make minor changes to the insurance terms and conditions and other terms of contract provided that the changes do not affect the primary content of the insurance contract.

If the insurance company alters the insurance contract as outlined above, it will, when sending an insurance bill, notify the policyholder of the changes in the insurance premium and other terms of contract. The notification shall state that the policyholder has the right to cancel the insurance.

The change will take effect from the beginning of the next insurance period following one month from the date the notification was sent.

The insurance contract may also change in accordance with clause 13.4 below concerning index regulations.

In addition to the above, the insurance company has the right to make changes as a result of bonus, customer loyalty and owner-customer rules and other similar rules applied to the insurance policy. The amount of the insurance premium is also affected by any customer bonuses or discounts, the amounts of which, the grounds of and durations and periods of validity may vary.

Changes requiring termination of insurance

If the insurance company alters the insurance terms and conditions, premiums or other terms of contract in cases other than those listed above or discontinues an actively marketed benefit, the insurance company must give written notice of termination of the insurance as of the end of the insurance period. The notice will be sent one month before the end of the insurance period at the latest. However, changes to the terms and conditions are not possible in the case of life insurance.

13.4 Effect of the index

The application of any index to an insurance contract is always mentioned in the insurance policy. Insurance which has no reference to any index in the insurance policy is not index-linked.

In the case of MyHome Insurance, the premiums, maximum compensation and deductibles are all linked to the construction cost index. The premiums, maximum indemnities and deductibles for the insurance for home contents in blocks of flats and terraced houses and for the insurance for parts of flats as well as for the insurance for stored home contents are, however, linked to the Finnish consumer price index.

The sums insured recorded in the policies for luggage, small boat, liability and legal expenses insurance as the Lessor's liability, legal expenses and consequential loss insurance are linked to the consumer price index. The deductible specified in the insurance policy is also linked to the consumer price index.

In the case of forest insurance and forest fire insurance, the premium is linked to the forest insurance premium index and the deductible to the consumer price index. The maximum compensation and the amount of benefit under Health Insurance are linked to the price development in the latest index series of the consumer price index subgroup related to products and services in the health sectors. The maximum compensation and the amount of benefit under Living Allowance Insurance, Pohjola Traveller's Insurance, Life Insurance and Disability Insurance are linked to the latest series of the consumer price index. If, however, the amount of benefit decreases with age in Life Insurance and Disability Insurance, the insurance premium is linked to the consumer price index.

Insurance policies to which the terms and conditions of Insurance no longer sold apply

In the case of life insurance, disability insurance and traveller's insurance, the sums insured recorded in the insurance policy are linked to the consumer price index. The sums insured of medical expenses insurance and accident insurance are linked to the consumer price index subgroup related to the price development of products and services in the health sectors. If, however, the sum insured decreases with age or is not expressed in euros owing to the type of compensation, the insurance premium is linked to the consumer price index. In the case of medical treatment expenses insurance, medical treatment insurance, medical expenses insurance and accident insurance, the deductible expressed in euros and the premium are linked to the consumer price index subgroup related to the price development of products and services in the health sectors.

In the case of non-life insurance, the sums insured recorded in the policies for moveable property, luggage, liability and legal expenses insurance are linked to the consumer price index. The sum insured recorded in the property insurance policy for buildings is linked to the construction cost index. In the case of full-value property insurance, the insurance premium is linked to the consumer price index as regards moveable property and to the construction cost index as regards buildings. The maximum compensation recorded in the insurance policy for moveable property is linked to the consumer price index. The deductible specified in the insurance policy is also linked to the consumer price index.

13.4.1 Index clause for the sum insured

The benchmark index used is the calendar month index four months before the first day of the insurance period. The sum insured recorded in the insurance policy is adjusted at the beginning of every insurance period by the same percentage as the benchmark index deviates from the benchmark index most recently used.

As of the beginning of the insurance period, the insurance premium is altered to match the adjusted sum insured.

The sum insured is rounded off to the nearest full euro.

In the case of non-life insurance, the ratio of the sum insured at the moment of loss or damage to the sum insured recorded in the insurance policy will be identical to the ratio of the calendar month index four months before the loss date to the benchmark index most recently used. In such a case, however, the sum insured at the moment of loss will be a maximum of 15% above the sum insured recorded in the insurance policy or the sum insured adjusted at the beginning of the previous insurance period.

13.4.2 Index clause for the premium

The benchmark index used is the index for September of the calendar year preceding the first day of the insurance period. However, as regards forest insurance, the benchmark index used is the index of the calendar year preceding the first day of the insurance period. The insurance premium for each insurance period is changed by the same percentage as the benchmark index deviates from the benchmark index most recently used.

In insurance policies based on sums insured, the sum insured for the insurance period changes to match the adjusted insurance premium.

When the amount of benefit decreases with age in life insurance and disability insurance, the amount of benefit is determined on the basis of the premium. The premium for impaired risk is calculated from the amount of benefit.

13.4.3 Index clause for maximum compensation under MyHome Insurance

The benchmark index used is the index for September of the calendar year preceding the first day of the insurance period. In the case of full-value insurance for building, moveable property and parts of a flat/house, the maximum compensation, recorded in the insurance policy, is adjusted at the beginning of every insurance period by the same percentage as the benchmark index deviates from the benchmark index most recently used.

The maximum compensation is rounded off to the nearest full euro.

13.4.4 Index linking of maximum compensation and sums insured under Health Insurance, Living Allowance Insurance, Pohjola Traveller's Insurance, Life Insurance and Disability Insurance.

The benchmark index used is the index for September of the calendar year preceding the first day of the insurance period. The maximum compensation amounts and the amounts of benefit recorded in the insurance policy are adjusted at the beginning of every insurance period by the same percentage as the benchmark index deviates from the benchmark index previously used.

The insurance premiums in both Life Insurance and Disability Insurance are made to correspond with the adjusted amount of benefit.

The maximum compensation and the amounts of benefit are rounded off to the nearest full euro.

13.4.5 Index linking of maximum compensation under non-life insurance and insurance of the person to which the terms and conditions of Insurance no longer sold apply

The benchmark index used is the index for September of the calendar year preceding the first day of the insurance period. In the case of full value insurance for moveable property, the maximum compensation, recorded in the insurance policy, is adjusted at the beginning of every insurance period by the same percentage as the benchmark index deviates from the benchmark index most recently used.

The maximum compensation is rounded off to the nearest full ten euros.

13.4.6 Index clause for the deductible

The benchmark index used is the index for September of the calendar year preceding the first day of the insurance period. The deductible recorded in the insurance policy is adjusted at the beginning of every insurance period by the same percentage as the benchmark index deviates from the benchmark index most recently used.

The deductible is rounded off to the nearest full euro.

14 Termination of insurance contract

14.1 Policyholder's right to terminate the insurance (§12)

The policyholder has the right, at any time, to terminate the insurance contract during the insurance period. Termination must be communicated in writing. Notice of termination given in any other manner shall be null and void. If the policyholder has not specified a later termination date for the insurance, the insurance will terminate on the date the notice was submitted or sent to the insurance company. However, the right of termination does not exist if the agreed period of validity of the insurance contract is shorter than 30 days.

Notice given to one of the insurance companies is also valid for the other insurers.

14.2 Insurance company's right to terminate non-life insurance during the insurance period (§15)

The insurance company has the right to give notice of termination of the insurance during the insurance period if

- the policyholder or the insured person has, before the insurance was granted, provided incorrect or insufficient information and the insurance company, had it known the circumstances, would have refused to grant the insurance
- during the insurance period, a change which has substantially increased the risk of loss or damage has occurred in the circumstances recorded in the insurance policy or reported by the policyholder or insured person to the insurance company at the time of concluding the contract, and which the insurance company cannot be deemed to have taken into account when concluding the contract
- the insured has wilfully, or through gross negligence, failed to observe the safety regulations
- the insured has wilfully or through gross negligence caused the insurance event, or
- the insured person has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability.

14.3 Insurance company's right to terminate insurance of the person during the insurance period (§17)

During the insurance period, the insurance company has the right to terminate the insurance or to terminate the cover for an individual insured person under Sports Cover if

1. the policyholder or the insured person has wilfully or through negligence which cannot be deemed minor, neglected their obligation to disclose information as referred to in clause 2.1 above, and the insurance company, had it been given correct and complete information, would have refused to grant the insurance altogether
2. the policyholder or the insured person has acted fraudulently in observing their obligation to disclose information as referred to in clause 2.1 above and, regardless of this, the insurance contract is binding on the insurance company on the basis of that clause
3. during the insurance period, a change as referred to in clause 5 above has occurred in the circumstances reported by the policyholder or the insured person to the insurance company at the time of concluding the contract, and the insurance company would not have granted the insurance in the event that the circumstance relating to the insured person would already have corresponded to the change when the insurance company granted the insurance
4. the insured person has wilfully caused the insurance event; or
5. the insured person has, after the insurance event, fraudulently provided the insurance company with incorrect or insufficient information relevant to the assessment of the insurance company's liability.

14.4 Procedure when the insurance company terminates an insurance policy during the insurance period

Having been informed of the grounds for permitting termination, the insurance company will give written notice of termination without undue delay. The notice of termination contains mention of the grounds for termination. The insurance contract will terminate one month from the time the notice was sent.

The insurance company's right to give notice of termination of insurance owing to an outstanding insurance premium is defined in clause 4.2 above.

14.5 The insurance company's right to terminate non-life insurance at the end of the insurance period (§16)

The insurance company has the right to give notice of termination of an insurance effective as of the end of the insurance period. The notice of termination contains mention of the grounds for termination. The notice will be sent one month before the end of the insurance period at the latest.

14.6 The insurance company's right to terminate insurance of the person at the end of the insurance period (§17a)

The insurance company has the right to terminate a contract of insurance of the person effective as of the end of the premium period. If the premium period is less than one year or its length has not been agreed, the insurance company has the right to terminate the insurance effective as of the end of the calendar year. The notice of termination will be sent one month before the end of the premium period at the latest or, if the premium period has not been agreed, one month before the end of the calendar year at the latest. Notice of termination has a mention of the grounds for termination.

Notice of termination of the insurance cannot, however, be given if the grounds are that the state of health of the insured has deteriorated since the time the policy was taken out, or that an insurance event has occurred.

However, in the case of life insurance or disability insurance, the insurance company does not have the right to give such notice.

14.7 Change of owner (§63)

If the insured property is transferred to a new owner other than the policyholder or the policyholder's death estate, or when the holder of a vehicle sold on hire purchase becomes the owner, the insurance for that property will terminate. If an insurance event takes place within 14 days of the transfer of ownership, the new owner will, however, be entitled to compensation unless he/she has taken out insurance on the property.

In legal expenses and consequential loss insurance policies included in an insurance package for motor vehicles, the insurance contract will terminate if the insured property is transferred to a new owner.

14.8 Notice of termination of life insurance (§21)

If the life insurance has been valid for more than a year, the insurance company will send the policyholder a reminder one month before the termination of the validity period at the latest, and three months at the earliest.

If the insurance company fails to send this reminder, the life insurance remains valid. However, the period of validity terminates in one month's time from the date on which the delayed reminder was sent to the policyholder and at the latest in six months' time from the end of the validity period of the insurance.

15 Digital services

If the policyholder has concluded a private customer's digital services agreement, the policyholder may attend to personal insurance matters using OP's digital services, such as the op.fi service. Use of the services is possible to the extent determined by OP. This may include the right to view the details of insurance policies in force or to file loss reports. When the policyholder uses OP's digital services to attend to insurance matters, the general terms and conditions for private customer's digital services, which are supplied to the customer when concluding the agreement, shall apply to the insurance in addition to these insurance terms and conditions.

The insurance company is entitled to send all insurance-related information, such as decisions, messages, notifications, responses, changes and notices of termination, exclusively in electronic form to OP's online and mobile services. The policyholder has the right to receive the aforementioned information by post within reasonable time from the day on which the policyholder informed the insurance company of the wish to receive the information by post.

16 Statutory right to perform profiling

When performing its risk management duties stipulated by the Insurance Companies Act and other relevant regulation, the insurance company has the right to perform profiling.

17 Applicable law and calculation bases

Finnish law shall apply to all insurance contracts, and the calculation bases required by the Insurance Companies Act shall additionally apply to personal insurance.

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OP Life Assurance Company Ltd, Business ID 1030059-2

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Regulatory authority: Financial Supervisory Authority, www.fiva.fi

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