Plus Health Insurance Group policy

Insurance terms and conditions valid as of 1 January 2018

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Read the cover restrictions and exclusions carefully.

Contents

PLUS HEALTH INSURANCE COVER GROUP INSURANCE

1 Those insured

Those insured are the persons whom the policyholder has reported in writing to the Insurance Company and whose inclusion in the insurance has been approved by the Insurance Company.

2 Content of insurance

This insurance covers examination or treatment expenses in accordance with these terms and conditions and incurred by the insured person owing to illness or injury sustained by him/her during the validity of his/her insurance cover. The insurance policy shows the maximum amount of coverable medical expenses and the deductible, if any.

3 Insurance contract

The content of the insurance contract is defined in the insurance policy, the insurance terms and conditions and the bases of calculation. In addition, the Finnish Insurance Contracts Act (543/94) and other relevant Finnish legislation apply to the contractual relationship.

4 Coverable medical expenses

Medical expenses are covered provided that the examination or treatment of illness or injury is prescribed by a physician.

Such medical expenses are

- charges for examination or treatment performed by a physician or any other healthcare professional
- charges for laboratory tests;
- costs for medicinal products and wound dressings sold in pharmacies
- daily hospital charges either in full or up to a certain maximum daily amount, as specified in the insurance policy;
- costs of examination and treatment of dental injury caused by an accident and
- costs of dental care provided that such care was necessary to heal a systemic illness;
- costs of physiotherapy necessary for recovery from a surgical operation or plaster treatment. Physiotherapy is also covered in knee and shoulder illnesses or injuries in which the physiotherapy is applied instead of surgery. A maximum of one physiotherapy period consisting of up to ten (10) sessions is coverable per surgical operation or plaster treatment and physiotherapy given instead of surgery.

5 Exclusions related to compensation

The insurance covers only the portion of medical expenses for which compensation has not been paid or for which the insured person is not entitled to compensation under the Health Insurance Act or some other legislation.

However, the insurance does not cover medical expenses incurred due to

- examination or treatment which was not based on generally accepted medical practice and which was not necessary for the treatment of the illness or injury in question;
- pregnancy, childbirth, abortion or infertility testing or fertility treatment;
- acquiring an anthroposophic or a homeopathic products or a mineral, nutritive or vitamin preparation
- abuse of alcohol or medicine or use of an intoxicant
- examination or treatment provided by a physiotherapist, foot therapist, chiropractor, osteopath, naprapathy practitioner, masseur or equivalent health care professional, with the exception of the situation specified in clause 4 above
- rehabilitation;

- correction of refractive errors;
- examination or treatment related to outward appearance or looks
- examination or treatment 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, unless it is a case of obesity surgery that fulfils the criteria for public health care
- examination or treatment related to transsexuality, other sexual identity disorder or disorder of sexual preference
- 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 case of medicinal products that have been compensated under the Health Insurance Act.
- participation in sport games or matches arranged by a sports
- association or sports club, or in related training. By competitive sports we mean sports games or matches arranged by a sports association or sports club and training arranged according to a training programme or other training typical of the sport, regardless of the age of the insured person. However, we do not consider non-competitive or over-35 sports organised as part of a sports federation and sports club as competitive sports.

  By training arranged according to a training programme we mean 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 done as part of preparation to games or sports.

  However, if it has been agreed upon and entered in the insurance policy, the insurance is also valid in competitive sports.
- participation in a war or armed conflict abroad; or
- sudden impact of a weapon or device based on nuclear reaction that has killed a large number of people.

6 Validity of insurance and insurance cover

The policy's inception date is the first day of the month following the month during which a written insurance application was submitted to the Insurance Company and subsequently approved by the latter. If separately agreed, the policy's inception date may also be the first day of a later month.

In the case of an individual insured person, insurance cover begins on the inception date of the policy. If the policyholder subsequently notifies the insurance company of the inclusion of a person in the insurance, the latter's insurance cover will begin on the first day of the month following such notification. In order for the insurance cover to commence, the insured person must meet the criteria for inclusion in the insurance in accordance with the risk selection principles applied by the insurance company.

The insurance period is one year. Upon expiry of this period, the policy will be renewed for one year at a time unless it is cancelled.

The insured person's insurance cover ceases to be effective as a result of his dismissal. Moreover, the insurance cover ceases to be effective on the first day of the month following the month during which the policyholder informed the insurance company that the insured person is no longer a member of the group of persons covered by the insurance contract or during which the insured person reached the age specified in the policy. The insurance cover also ceases to be effective when the maximum compensation laid down in the policy has been exhausted or the insured person dies.

7 Premium and payment of premium

The insurance premium is determined on the basis of the composition of the group of those insured and the extent of the insurance cover, in accordance with the bases of calculation applied to the insurance.

The Insurance Company will send the policyholder an insurance premium invoice no later than one month before the due date, which is the first day of the insurance period, at the earliest. The insurance premium must be paid by the due date.

If the premium has not been paid by the due date, the insurance company has the right to terminate the policy no sooner than 14 days from the dispatch of the notice of termination.

If the premium for terminated insurance, including penalty interest as provided by the Interest Act, is paid before the end of the notice period, the insurance will remain effective despite the notice of termination.

Any changes in the insurance premium due to changes in the group of those insured during the insurance period will be taken into account by adjusting the premium later during the insurance period.

The insurance company will charge the minimum premium specified in the insurance policy, insurance terms and conditions or other contract made between the insurance company and the policyholder.

8 Termination of insurance

The policyholder and the insurance company have the right to give written notice of termination of the insurance effective as of the end of the insurance period. Such notice must be sent two months before the end of the insurance period.

If the premium has not been paid by the due date, the insurance company also has the right to terminate the policy before the end of the insurance period, in accordance with clause 7 above.

The insurance company has the right to give notice of termination of the insurance cover of an individual insured person if the policyholder or the insured person, at the time the insured person was included in the insurance, provided the insurance company with incorrect or insufficient information and the insured person would not have been included in the insurance had correct or complete information been provided.

9 Insurance information given to those insured

Through the contact person reported to the insurance company and in the manner deemed appropriate in view of the circumstances, the policyholder shall provide those insured with the following information:

- essential information on the insurance cover of those insured sent annually to the policyholder by the Insurance Company, and
- any notification that the policyholder or the Insurance Company has given notice of termination of the insurance policy.

10 Claims and payment of compensation

Claimants must, at their own expense, obtain and send the insurance company a written report on the insurance event and other documentation required for settling a claim by filling in the insurance company's claims form accompanied by receipts and documents submitted to the insurance company.

If the insured person has a customer card enabling direct debiting, such a report on the insurance event may also be send by a provider of health services or some other party billing treatment expenses, in accordance with guidelines agreed separately with the insurance company.

The claimant must pay the expenses him/herself before claiming for 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 (Kela) within six months of paying the expenses. The claimant must upon request provide the insurance company with the original claim settlement decision for the reimbursement paid by the Social Insurance Institution, plus copies of original receipts submitted to the Social Insurance Institution.

If the insured person has a customer card enabling direct debiting, it may be used on the condition that the provider of the healthcare service or some other party billing treatment expenses deducts from the bill the portion compensated under the Health Insurance Act, after which the remaining amount may be charged to the insurance company. Users of customer cards must also present their valid Kela card (social security card).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, compensation can be reduced or disallowed, depending on what is reasonable in the circumstances.

The insurance company will pay compensation, or inform the claimant of its non-payment, no later than one month of the date the aforementioned documents were provided. The Insurance Company will pay interest on any delayed payment in accordance with the Interest Act.

11 Set-off

The insurance company may deduct from compensation any outstanding premiums overdue and other outstanding amounts in accordance with general set-off requirements, should the beneficiary be the policyholder.

12 Time limitation on claims

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 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 his/her right to obtain compensation.

If the insurance company also pays the insured person the portion of the medical expenses coverable under the Health Insurance Act, the original expense voucher and the application to the Social Insurance Institution must be submitted to the insurance company within four (4) months of the date on which the insured person paid the medical expenses concerned.

13 Index clauses

On the first day of the insurance period, the insurance cover, premium and total amount of compensation already paid are annually raised to correspond to an increase in the cost-of-living index, based on the index for September.

14 Altering terms and conditions of insurance contract

The insurance company has the right to alter the insurance premium and other contract terms as of the beginning of the subsequent insurance period if the reason for such an alteration is due to unpredictable developments in claims expenditure or any of the following unpredictable changes in circumstances:

- new or amended legislation or a regulation issued by the authorities
- an international crisis, exceptional natural phenomenon, catastrophe
- change in mortality rates;
- a fall in interest rates below the interest rate used in the calculation of insurance premiums, or
- a change in the cost level affecting the insurance, provided that said change is due to a reason beyond the Insurance Company’s control.

However, an alteration of the contract terms involving a decrease in the insurance cover does not apply to an illness or bodily injury whose examination or treatment had begun before said alteration took effect.

The insurance company also has the right to make minor changes to the terms of contract provided that the changes do not affect the primary content of the insurance cover.

The insurance company has the right to incorporate an exclusion clause into the insurance cover of an individual insured person if the policyholder or the insured person has given incorrect or insufficient information on the state of health of the insured person at the time of his/her inclusion in the insurance.

15 Lodging an appeal

The policyholder or claimant has several ways of appealing against a decision taken by the insurance company. If the matter remains unsettled after he/she has contacted the insurance company, he/she can ask for advice and counselling from the Finnish Financial Ombudsman Bureau or request a decision recommendation from the relevant board. A policyholder or claimant who is dissatisfied with the insurance company's decision may also bring action against the insurance company in court.

15.1 Right to correct

If a policyholder or claimant suspects that the insurance company has made a mistake in its claim settlement decision, he/she has 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.

15.2 Finnish Financial Ombudsman Bureau and boards issuing recommendations

Policyholders or claimants dissatisfied with the insurance company's decision may ask the Finnish Financial Ombudsman Bureau for advice and counselling. The Bureau is an impartial body whose function is to advise consumers in insurance and claim matters.

The insurance company's decision can be submitted to the Finnish Insurance Complaints Board operating in conjunction with the Finnish Financial Ombudsman Bureau. The Board's function is to make recommendations for decisions in disputes which concern interpretation and application of the law and insurance terms and conditions in an insurance relationship.

These boards will not handle a case while it is pending or when a ruling has been given in court.

The counselling services and board statements are free of charge.

15.3 District court

If the policyholder, insured person or another claimant is dissatisfied with the insurance company's decision, he/ she may bring action against the insurance company in the district court of his/her domicile in Finland, of the insurance company's domicile or of the place of loss in Finland, unless otherwise provided by Finland's international agreements.

Action against the insurance company's claim settlement decision must be brought within three years of the policyholder or claimant being informed in writing of 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.

Pojola Insurance Ltd, Gebhardinaukio 1 00013 OP, domicile Helsinki, main line of business insurance. The company has been entered in the Trade Register, Business ID 1458359-3.
A-Insurance Ltd, Gebhardinaukio 1 00013 OP, domicile Helsinki, main line of business insurance. The company has been entered in the Trade Register, Business ID 1715947-2.