DSS-HÄLSA

Terms and conditions healthcare insurance

Content

1 General

1.1 About the insurance

The insurance agreement consists of:

1. The group agreement.
2. Insurance statement with related documents.
3. These insurance conditions.

If the three different parts of the insurance contract contain contradictions, interpretation priority shall be given in the same order as they are listed above.

The insurance contract is governed by the provisions of the Swedish Insurance Contracts Act (2005:104) and other applicable Swedish insurance regulations. The Swedish Financial Supervisory Authority (Finansinspektion) is the supervisory authority responsible for the Swedish insurance market.

1.2 Definitions

This section contains definitions of some occurring words used in these terms of conditions. Other words marked with an asterisk (*) are explained under the Glossary.

1.2.1 The insurance provider

The insurer is Forsikringsselskabet Dansk Sundhedssikring A/S, organization number: CVR.nr. 34 73 93 07. The board of the company has its seat at Hørkær 12B, 2730 Herlev, and is under the Financial Supervisory Authority as a skadesforsikringsselskab.

The administrator and Swedish representative for this insurance is DSS Hälsa AB org.no. 556751-0424, Vasagatan 10, 111 20 Stockholm, Sverige. DSS Hälsa AB is under the supervision of the Swedish Financial Supervisory Authority (Finansinspektion).

The insurer and the Swedish representative are jointly referred to hereinafter as “the Company", “we”, “us”, “our” or “ours”.

1.2.2 The policyholder

The policyholder is the person/company who the Company has agreed an insurance contract with.The policyholder must be registered with an organization number or social security number in Sweden. A company must be located in Sweden unless otherwise stated in the policy or group agreement.

1.2.3 The insured

The insured is the person or group of persons on whose health the insurance applies, also defined as “the group”.

1.2.4 The insurance period

The insurance period is the period from when the insurance enters into force until it ends, for whatever reason. Unless otherwise agreed, the insurance period is always 1 year.

1.2.5 The group agreement

The group agreement is an agreement between the Company and the group representative, and is the basis for the validity of the group insurance. Thus, the validity of the group agreement is a prerequisite for the validity of each person's insurance.

1.2.6 The insurance policy

The insurance policy is the written contract between the Company and the policyholder which determines the terms under the insurance. Any agreed special conditions or limitations to the insurance will be listed in the insurance policy.

1.2.7 Group representative

Group representative is the one representing the group of insured persons. The group representative can for example be a broker, an employer or another external group administrator.

1.2.8 Mandatory group insurance

The mandatory insurance is taken out by an employer or organization (the group representative) for its employees or members, whereby each group member is directly covered due to the group agreement.

1.2.9 Voluntary group insurance

The voluntary insurance is taken out by voluntary application by persons in an open group defined by the Company or by the same persons not rejecting the insurance.

1.3 When does the insurance apply

The insurance applies during the insurance period. The insurance will come into effect at the time agreed between the policyholder and the Company.

1.4 Where does the insurance apply

Insured and co-insured are covered with examination and treatment in Sweden. No costs are covered in connection with the return to Sweden in case of being posted outside Sweden.

1.5 Transfer from another group or insurance company

1.5.1 Voluntary group transfer

If the policyholder, insured or group representative has moved his/hers or the group's corresponding insurance policy from another insurance company, no claims that the former insurance company has approved to cover will be covered, unless there is a specific agreement to take over the insurance liability.

1.5.2 Mandatory group transfer

If a mandatory insured group with an equivalent existing insurance cover with another insurer is transferred as a whole or as a defined group, it is required that the Company approve all insured persons in the defined group after the group has been risk assessed, and before the group is incepted to this insurance.

In the event of a transfer as described above, the insurance cover symptoms that occur after the due date of transfer of this insurance. Symptoms occur before the transfer of the insurance, the Company need to accept all ongoing treatments in accordance with these insurance terms and conditions.

If the insurance was originally accepted with moratorium of pre-existing condition the insured will be credited the seniority established with the former insurance company. For the Company to accept seniority, a documented and valid start date on the previous insurance contract must be reported to the Company.

1.5.3 Group transfer within the Company

Insured persons who have a valid voluntary or mandatory insurance within the Company taken out via an intermediary, partner or directly via the Company, and who change group contract affiliation and take out a new insurance within the Company with uninterrupted insurance period, may credit previous insurance period with the Company. This also applies if the insured has had an individual insurance and takes out a new insurance under a valid voluntary or mandatory group insurance contract within the Company.
.

1.6 Renewal and changes

The premium and conditions during the current insurance period will be renewed for the coming period unless this is changed by the Company. Information about changes is given in connection with premium payment and renewal of the new insurance period.

The company also has the right to change the terms of the insurance notice during the current insurance period if the conditions for the contract are changed through changed legislation or changed regulations, changed applications of laws, regulations or other authority regulations.

1.7 Handling of personal data

The Company respects and protects the personal integrity of all customers, policy holders, insured and everyone else that we process personal data relating to. We do not collect more personal data than what is needed, and we process all data only if we have a right to do so.

What data that is collected and how we handle the personal data depends on which products you have with us, who is the policy holder etc. It may involve information that someone provides to us for themself or on behalf of another person when applying for an insurance, or that someone provide during the course of a business relationship or during an insurance event. Sometimes the Company also needs to process information about someone's health, union membership or private economy to be able to determine for instance if someone is eligible for a certain insurance product.
The Company may process health data based on consent when an insurance event is reported and we refer an insured to treatment.
As part of managing the health insurance, we may also transfer personal data to third parties based on consent.
All information is handled with confidentiality and is protected both via technical solutions and strict requirements on all employees.
Please visit The Company's Privacy Policy at www.dss-Halsa.se for more information about how we process personal data and how data subjects can exercise their rights Privacy Policy

For contacting the Company's data protection officer (DPO) please use the e-mail address info@dss-halsa.se or telephone number 08 – 40 00 61 22.

1.8 The Swedish common claims register

The Company has the right to report registered claims to the Swedish claims register (Joint claims registration register, GSR).

1.9 Premium

The first premium must be paid within 30 days from the day we sent the invoice or premium notification. Renewal premium must be paid before the new insurance period but not earlier than 30 days from the day we sent the invoice or premium notification.

If the premium is not paid on time, we will terminate the insurance, which expires 14 days after the time of termination unless the premium is paid within this time. The date of termination is the day on which we sent notice of cancelation.

If the premium of a voluntary group insurance can not be paid within the 14-day deadline due to a group member becoming seriously ill, deprived of liberty, has not received a pension or salary from his or hers main employment, or similar obstacles, the termination shall take effect no earlier than 2 week after the obstacle expired, but no later than 3 months after the original 14-day deadline.

If the insurance has expired due to the non-payment of the renewal premium, it can be revived by paying the premium within 3 months from the date on which the insurance ceased. Premiums must be paid for the entire premium period for which the premium has been unpaid. The insurance will then be valid again from the first day of the premium period.

An insured who leaves the group shall immediately inform us or the group representative about this. If not done in due time we will reimburse paid premiums no longer than 12 months within the current insurance period. The Company reserves the right to cover its administrative costs when reimbursing premiums.

The insurance does not entitle to any premium exemption.

1.10 Post-employment cover

If an insured has been covered by the insurance for at least 6 months, an extended insurance cover applies for 3 months after leaving the group. If a spouse, registered partner or cohabitant is co-insured and the relationship is dissolved, the co-insurance for the co-insured ends 3 months after the marriage / partnership / cohabitation relationship has ended.

Post-employment cover does not apply:

1. if the insured has received or obviously can get the same kind of insurance coverage as previously in some other way e.g. other group insurance or continuation insurance,
2. when the insured has reached the final age in the group agreement. If the final age is reached during the post-employment period, the post-employment cover terminates.
3. if the insured has chosen to terminate the insurance himself but still belongs to the insured group.

1.11 Continuation insurance

If an insured has been covered by the insurance for at least 6 months the insured is entitled to continuation insurance if:

1. the insurance contract terminates due to the termination of the insured's employment, or
2. the insured no longer belongs to the category of persons covered by the insurance contract,
3. the insurance terminates due to termination by the Company or the group, or
4. the insurance defined as a mandatory insurance terminates due to missing payment by the employer or the group administrator.

If an insured has been covered by the insurance for at least 6 months the co-insured is also entitled to continuation insurance if:

1. the insured dies,
2. marriage, registered partnership or cohabitation with the insured dissolves, or
3. the insured reaches the maximum age of the insurance before the co-insured.

The right to continuation insurance does not apply:

1. if the insured is not resident and registered in Sweden when the group insurance ends
2. if the insured has received or obviously can get the same kind of insurance coverage as previously in some other way e.g. other group insurance or continuation insurance.

The terms of the continuation insurance may deviate from the terms and conditions for the group Insurance.

1.12 Liability period

DSS Hälsa's liability period applies until the insured reaches the end age of the insurance according to 2.3, provided that the insurance is in force. DSS Hälsa's liability period ends before then if the insurance ends (see, however, regarding post-coverage 1.10 and continuation insurance 1.11).

1.13 Transfer and deposit

The insurance contract cannot be transferred or pledged unless otherwise provided in the group agreement.

2 To whom the insurance cover

2.1 The insured

The insurance can cover persons or a group of persons, as a mandatory or voluntary policy. The insurance covers the persons who are registered and mentioned in the insurance policy.

2.2 Co-insured

Co-insured is the insured's spouse/registered partner/cohabitant/biological children and/or adopted children, who has been named in the insurance as stated in the policy and/or group agreement and who is registered on the same address as the insured.

It is a condition for taking out the group insurance for co-insured that the insured takes out the corresponding insurance for their own part.

Spouse/registered partner/cohabitant/ children who are not registered on the same address as the insured, can be co-insured if your spouse/registered partner/cohabitant has signed a voluntary insurance.

2.3 Requirement

The person insured and co-insured, respectively, must:

- be fully fit for work*
- has turned 16 years old,
- has not reached the age of 70,
- have a permanent registered address in Sweden and be a member of and fully covered by the public Swedish healthcare system through the Swedish social security, or
- have a permanent registered address in Norway (except Svalbard and Jan Mayen), Finland and Denmark (except Greenland and the Faroe Islands) and have the right to receive services equivalent to public health insurance benefits via public or private coverage in the country of residence. Exceptions will be stated in the policy.

The condition for taking out insurance for children is that the parent takes out the corresponding insurance for his own part and that the child to be insured:

- is completely healthy*,
- has turned 1 year old
- has not reached the age of 21,
- have a permanent registered address in Sweden and be a member of and fully covered by the public Swedish healthcare system through the Swedish social security, or
- have a permanent registered address in Norway (except Svalbard and Jan Mayen), Finland and Denmark (except Greenland and the Faroe Islands) and have the right to receive services equivalent to public health insurance benefits via public or private coverage in the country of residence. Exceptions will be stated in the policy.

Insurance for children is valid until the age of 25 at the latest.

2.4 Incorrect and incomplete information

Obligation to provide information.

The policyholder and the insured are obliged to provide, at DSS Hälsa's request, the information that may be relevant to the question of whether insurance is to be announced, changed or processed in any other way. The policyholder and the insured must provide correct and complete answers to DSS Hälsa's questions. DSS Hälsa may demand and is entitled to reimbursement for any insurance compensation that was paid out incorrectly or other costs for DSS Hälsa as a result of incorrect information. If the policyholder, the insured or someone with his/her knowledge has provided incorrect or incomplete information that is significant for the assessment of the insured's right to care or compensation from the insurance, this may result in the insurance contract being invalid or the compensation amounts being reduced in accordance with the provisions of the Insurance Contracts Act.

3 How to use your insurance

3.1 How to make a claim

3.1.1 Notification of a claim

In the event of accident, the policyholder and/or the insured can contact the Health team by telephone, e-mail or through DSS Hälsa's website, in accordance with rules that apply to the insurance element included in the insurance contract.

Any claimant who required compensation from the Company need to provide valid medical documents for ongoing claim/injuries that are important to determine the right to compensation. In some cases the company may require medical documentation from the insured to ensure the right to compensation. The costs for medical documentation and other documents are coverd by the Company and must be substantiated with original receipts.

3.1.2 Collection of information

Permission for us to obtain information from the physician, hospital, other healthcare institution, employer, group representative, Swedish insurance fund or other insurance institution for assessment of the insured's right to compensation and the validity of the insurance must be provided if we so request.

3.1.3 Time for payment of compensation

We pay insurance compensation no later than 1 month after the right to compensation has been entered into and the claimant has completed what is required. We pay interest in accordance with Swedish law or other applicable regulations.

3.2 Examination and treatment must be approved in advance

The insurance covers examination, treatment and additional services covered by the insurance which takes place during the insurance period.

All claims expenses must be pre-approved, planned and booked by our medical service office. It is therefore important that the insured does not initiate treatment without prior approval, as we may otherwise reject cover. This also applies if changes occur in the treatment.

3.3 Pre-existing conditions

Unless otherwise stated in the insurance policy, the insurance does not cover any pre-existing conditions, such as any illness that has shown symptoms, been recorded, treated or known by the insured before the insurance came into force.

A pre-existing condition can be accepted as a new valid insurance event, and thus covered by the insurance, if the insured for a consecutive period of 12 months prior to the inception date has been completely free of any symptom, medical treatment, never needed or received any medical advice, received drugs or special diets relating to a pre existing condition. The same applies if the insured has been symptom-free for and treatment-free for more than 12 consecutive months during the insurance period.

3.4 Choice of treatment and treatment provider

We cooperate with a network of quality-assured private hospitals and specialists. The insured must use the healthcare provider appointed by our Health team. However, for certain types of treatment, the insured may choose a specialist who is not part of our network after approval from our Health team.

It is a requirement that the treatment is available in Sweden within the public healthcare system or through our network of private healthcare providers. The care must follow the National Board of Health and Welfare's guidelines and be carried out in accordance with medical science, established methods, proven experience and in a manner that follows from laws and regulations as well as the regulations and general advice of the supervisory authority.

3.5 Examination and treatment guarantees

The insured is guaranteed a reimbursable examination and/or treatment within 7 working days at a specialist in private healthcare, after we have approved the examination/treatment.

For an insurance event involving surgery or hospitalization, the insurance guarantees the insured right to surgery within 20 working days for Hälsa BAS and 14 working days for Hälsa PLUS and PREMIUM from the time we approve the request.

If we need more information, such as a doctor's referral or other relevant information, the working days will be counted after the information has been received and approved.

If we are unable to fulfill the treatment guarantee, an amount of SEK 500 per working day will be paid to the insured. The compensation is paid the day after the guarantee day and until the insured receives the guaranteed treatment. In all cases, the total maximum amount paid is the equivalent of an annual premium cost for the insured.

If the treatment consists of several approved and planned hospitalizations, the guarantee only applies to the first consultation. If an examination/treatment has to be postponed due to medical reasons or if the insured does not accept the proposed time, the treatment guarantee does not apply. The treatment guarantee only applies to healthcare that is available within the private or public healthcare system in Sweden.

3.6 Annual maximum insurance cover

The maximum insurance coverage and compensation limit per year, insured and damage is SEK 1 million for Health BAS, SEK 2 million for Health PLUS and SEK 3 million for Health PREMIUM.

3.7 Deductible

If the insurance was taken out with a deductible, this is stated in the insurance statement. Deductible does not apply if the insured:

- receives treatment within publicly funded care, up to the high-cost cover. The same applies to e-medical care booked with general practitioners by us.
- if the insured can present a referral issued by a doctor in public care for each new insurance case, the insured does not have to pay a deductible. Previously paid excess is not refunded if the insured receives a referral later during the treatment period.

3.8 Referral

If the insurance was taken out with or without a requirement for a referral, this is stated in the insurance notice. If it appears in the insurance notice that the insurance must apply with a requirement for a referral, this means that the insurance does not cover care or costs before a referral has been issued by a doctor in public healthcare.

A referral is valid for 6 months from the date of issue.

3.9 Prescription

The right to compensation or other cover under this insurance ceases if the insured does not bring any action against the Company within ten years from the time when the circumstance occurred that could entitle the insured to a compensation or cover.

However, an insured who has submitted the claim to us within the time specified above, always has six months to bring an action against us from the day we have declared that we have taken a final position to the claim.

3.10 Right of recourse

The Company enters into the insured's right to seek compensation from others to the extent that the Company has provided compensation due to this insurance contract.

4 This is included in the insurance

DSS Health's health insurance is divided into three different levels:
Health BAS, Health PLUS and Health PREMIUM. The level that applies to a specific group has been agreed in the group agreement and appears in the insurance statement.

4.1 Hälsa BAS

4.1.1 Patient fees and care costs

The insurance covers your patient fees as a patient for public care up to the high-cost cover. Also applies to patient fees in connection with emergency visits to publicly funded care.

In cases where we refer you to a private clinic or hospital for treatment, payment will be made directly between us and the private healthcare provider. We do not reimburse expenses that public health care has already fully or partially reimbursed. We do not reimburse expenses that public care has offered to cover unless the waiting time within public care exceeds three (3) months.

Approved claims for compensation are limited to necessary and reasonable costs in the region where the treatment is approved.

4.1.2 Healthcare Navigator

Our Health team helps the insured with medical advice from licensed nurses by phone on number 08 – 40 00 61 21 or through My DSS on DSS Hälsa's website. Our Health team has many years of experience from different specializations and offers professional advice on all health-related problems, including those that do not require treatment or are not covered by insurance.

Through our unique CareNavigator concept, we also offer advice on the public healthcare system's treatment options, such as patient rights, appeals process, guidance on waiting times, how to best contact your local healthcare center, or how to take advantage of the right to choose where you want to seek care. All examinations and public options in primary care are included. We also help review medical records and notes from hospitals and doctors, as well as other help if needed.

In the event that an injury can only be treated within public healthcare or is not compensated by the insurance, we offer the insured advice and support regarding the care and treatment that takes place within public healthcare.

4.1.3 Diagnosis of pain

The insurance covers examination and treatment of long-term pain at a pain clinic or headache clinic. Pain treatment due to cancer is not covered by the insurance. We help with counseling further in the treatment process.

4.1.4 Physician

The insurance covers necessary and reasonable costs for a compensable claim that has been approved by us in advance.

The compensation refers to examination/treatment/measures/operation for ailments/illness/injury carried out by doctors appointed by us.

Only investigation, treatment and surgery that can be accessed privately in Sweden are covered by the insurance. A further condition is that the private care in Sweden can receive the patient, taking into account the patient's state of health. The care must follow the National Board of Health and Welfare's guidelines and be carried out in accordance with medical science, established methods, proven experience and in a manner that follows from laws and regulations as well as the regulations and general advice of the supervisory authority.

4.1.4.1 Diagnostic imaging and tests

In cases where the attending physician or licensed therapist refers for diagnostic imaging and tests that are necessary and relevant to establish a diagnosis, it is a requirement that DSS Health approves this referral. The examination and treatment must primarily be carried out by a doctor as close to the insured's home in Sweden as possible.

In cases where a referral is issued by a doctor or licensed therapist in the claim case, referrals/examinations/treatments must always be approved in advance by DSS Health.

4.1.4.2 Skin conditions

The insurance covers the treatment of skin conditions that we believe affect the insured's state of health according to the current insurance conditions. We always help with advice, guidance in public healthcare for all skin conditions.

The insurance can cover treatment for skin cancer (basal cell cancer) on the above grounds.

4.1.4.3 Allergy diagnoses

The insurance replaces an examination to determine an allergy diagnosis. Depending on which symptoms the insured has, it is the company's Health team that determines the need for an examination.

4.1.4.4 Psychiatrist

The insurance covers necessary and reasonable costs for treatment by a psychiatrist. In order for the treatment to be reimbursed, it is required that there is a medical need to receive the treatment and that the treatment ensures an improvement in the state of health.

4.1.5 Digital care services

The insurance replaces digital care treatments and/or counseling by phone or video meeting with a nurse, psychologist or doctor.

4.1.6 Follow-up surveys

The insurance covers necessary and reasonable examinations in outpatient care, after surgery covered by the insurance, for up to 6 months from the date of the surgery. The examination must be prescribed by a relevant doctor and approved by us.

4.1.7 Medical rehabilitation after surgery/hospital care

The insurance covers medical rehabilitation with a maximum of 10 treatment sessions per claim for necessary and reasonable outpatient treatment carried out by a physiotherapist, naprapathy therapist and/or chiropractor in direct connection with a compensable insured event in the musculoskeletal system*. The rehabilitation must be prescribed by the treating medical specialist.

Group exercise instructed by a physical therapist is covered if it is approved by us and is part of a covered rehabilitation plan. Group training is covered with an amount corresponding to the insured's cost of the group training. Chiropractic treatment is covered with an amount corresponding to the insured's cost of general chiropractic care.

4.1.7.1 Medical rehabilitation within our network of private healthcare providers

The insurance covers a maximum of 10 treatment sessions per claim which, based on a professional and healthcare-related assessment, are considered necessary and reasonable. The insured will be offered a consultation at a quality-assured clinic and we will settle the payment for the treatment directly with the therapist.

4.1.7.2 Medical rehabilitation outside our network of private healthcare providers

If the insured chooses a physiotherapist, naprapat or chiropractor without a care agreement who is not part of DSS Hälsa's care network, the customer is covered by SEK 500 per treatment session. The insurance covers a maximum of 10 treatment sessions per claim which, based on a professional and healthcare-related assessment, are considered necessary and reasonable.

The treatments are approved in predefined divisions. If more treatments are needed, the insured must contact our Health team who will evaluate and approve additional treatments.

We may request a status report or treatment plan from the therapist. The payment of the treatment must be made by the insured. When processing is completed, a copy of the original receipts must be sent to us.

4.1.8 Psychologist/psychotherapist

The insurance covers a maximum of 10 treatment sessions per compensable claim for necessary and reasonable treatment by a licensed psychologist or psychotherapist, if we believe it is possible to achieve a significant and lasting improvement in health. For the treatment to be covered, a referral from a physician may be required unless we determine that an appropriate treatment within our network of providers is preferable. We will continuously evaluate how many treatments the insured needs and whether the treatment is appropriate. In order for the treatment to be replaced, it is a requirement that there is a medically documented need for the treatment and that it intends to lead to an improvement of the condition.

If the insured chooses a psychologist/psychotherapist without a care agreement who is not part of DSS Hälsa's care network, the customer is covered by SEK 800 per treatment session.

4.1.9 Travel and accommodation

The insurance covers necessary and reasonable transport costs between the insured's home and hospital/clinic in connection with care covered by the insurance and as planned and arranged by our Health team when the total journey exceeds 200 kilometers, round trip.

The compensation per kilometer is compensated with a standard amount in accordance with the Swedish Tax Agency's rules for mileage compensation.

The insurance covers accommodation costs with a maximum of SEK 1,500 per day. The need must be approved by our Health team in advance.

Travel and accommodation must be approved by us in advance.

4.1.10 Coaching

Counseling over the phone regarding questions about well-being is available to the insured through our quality-assured network of psychologists, psychotherapists and other health professionals. The need for counseling can arise through various influencing causes such as private problems with relationships, lifestyle, addiction, stress, or work-related problems such as burnout, dismissal, bullying and conflicts. There may also be a need for professional coaching when you are a manager.

Our service is available weekdays during office hours and all treatments will be arranged by the Health team. We replace a maximum of five calls of 60 minutes per occasion. The number of treatments is based on the counsellor's professional judgement.

4.1.11 Childbirth

The insurance covers treatment by a psychologist, after referral from a doctor, for postnatal reaction, postpartum depression and other problems resulting from childbirth, in cases where we believe that the treatment can improve the patient's health permanently.

4.2 Hälsa PLUS

In addition to the elements described above under Hälsa BAS, the following elements are also included in Hälsa PLUS, unless otherwise agreed in the group agreement and shown in the insurance statement.

4.2.1 Assistance at home

The insurance covers necessary and reasonable expenses for temporary home help in direct connection with an operation that is covered by the insurance. The temporary home help or home health care must be prescribed by the treating medical specialist and approved by us in advance.

Temporary help for cleaning, handling, help with personal hygiene and undressing covers a maximum of 14 days from the day of discharge from hospital/clinic, and a maximum of 20 hours in total including travel time.

4.2.2 Second/third opinion

In some cases, the insurance covers consultation with a relevant doctor if the insured:

- has a life-threatening or particularly serious illness or injury.
- faced with the choice of receiving particularly risky treatment, which may be life-threatening or result in permanent damage/s.

If we consider that the insured is entitled to a second opinion, a doctor from either a public or private healthcare provider will contact the insured, digitally or via a physical examination. If the insured is faced with a difficult decision or if there is uncertainty regarding a diagnosis or type of treatment, we offer an advisory consultation with dedicated doctors and nurses. If the two doctors do not agree on a diagnosis or type of treatment, we offer a third opinion by telephone.

4.2.3 Temporary aids

The insurance covers expenses for personal and temporary aids that are needed after an intervention or a treatment approved by us. The aids must be necessary and reasonable and must be prescribed by the attending physician. Temporary aids, including rented aids, are reimbursed for a maximum of 6 months.

4.2.4 Prescription drugs

In the event of a coverable claim, the insurance reimburses the insured's costs for prescription drugs up to the level of the high-cost cover. DSS health only covers costs that can be proven with original receipts. Prescription drugs must be prescribed by the attending physician and be necessary for the medical treatment.

4.2.5 Travel and accommodation

The insurance covers necessary and reasonable transport costs between the insured's residence and hospital/clinic in connection with care covered by the insurance and as planned and arranged by our Health team when the total journey exceeds 100 kilometers, round trip.

The compensation per kilometer is compensated with a standard amount in accordance with the Swedish Tax Agency's rules for mileage compensation.

The insurance covers accommodation costs with a maximum of SEK 1,500 per day. The need must be approved by our Health team in advance.

Travel and accommodation must be approved by us in advance.

4.2.6 Physiotherapist, naprapath, chiropractor and osteopath

The insurance covers necessary and reasonable costs for treatment by a physiotherapist, naprapath, chiropractor and osteopath. In order for the treatment to be covered, it is a requirement that there is a

medically documented need for the treatment and that it intends to lead to an improvement of the condition.

Based on the medical evaluation, we will refer the insured to relevant treatment. We will continuously evaluate how many treatments are needed and whether the insured is receiving the correct treatment.

If the insured chooses a physiotherapist, naprapath, chiropractor or osteopath without a care agreement who is not part of DSS Hälsa's care network, the customer is covered by SEK 500 per treatment session.

4.2.7 Acupuncture/zone therapy

The insurance covers necessary and reasonable costs for treatment by a physiotherapist, naprapath, chiropractor and osteopath. Because the insurance covers necessary and reasonable costs for treatment through acupuncture or reflexology. Treatment is covered with a maximum of 10 treatments per diagnosis/injury. In order for the treatment to be replaced, it is a requirement that there is a medically documented need for the treatment and that it intends to lead to an improvement of the condition. For acupuncture to be covered, it is also required that the underlying condition is on the World Health Organization's (WHO) list of conditions where acupuncture has had a positive effect.

Based on a medical evaluation, we will refer the insured to the relevant treatment. We will continuously evaluate how many treatments are needed and whether the insured is receiving the correct treatment.

If the insured chooses acupuncture or reflexology with a healthcare provider without a healthcare contract who is not part of DSS Hälsa's healthcare network, the customer is covered by SEK 500 per treatment session.

4.2.8 Psychologist/psychotherapist

The insurance covers necessary and reasonable treatment by a licensed psychologist or psychotherapist, if we believe it is possible to achieve a significant and lasting improvement in health. For the treatment to be covered, a referral from a physician may be required unless we determine that an appropriate treatment within our network of providers is preferable. We will continuously evaluate how many treatments the insured needs and whether the treatment is appropriate. In order for the treatment to be covered, it is a requirement that there is a medically documented need for the treatment and that it intends to lead to an improvement of the condition.

If the insured chooses a psychologist/psychotherapist without a care agreement who is not part of DSS Hälsa's care network, the customer is covered by SEK 800 per treatment session.

4.2.9 Crisis therapy

The insurance covers crisis therapy if we believe that the insured has experienced an acute psychological crisis due to any of the following:

1. if the insured has experienced a sudden serious event/accident, where the insured has been in danger.
2. if the insured has been the victim of robbery, assault, violence or kidnapping, fire, explosion or burglary of the insured's private home or business (must be reported to the police).
3. if the insured is diagnosed with a life-threatening illness.

4. death within the insured's immediate family*.
5. if a member of the insured's immediate family is diagnosed with a life-threatening illness.
6. if the insured experiences the sudden, unexpected death or sudden, serious event/accident of a family member or colleague.

It is not a requirement with a referral from a doctor. We assess whether crisis therapy or other treatment is required.

If we believe that the insured is in need of crisis therapy, we will find a psychologist for the insured in our network of healthcare providers. The subsequent course/treatment will depend on the nature of the accident and the professional judgment of the therapist.

If we become aware of the incident more than 48 hours after the cause of the crisis, regular psychological treatment is always replaced. Debriefing is only reimbursed as part of approved crisis therapy treatment.

4.2.10 Dietitian

The insurance covers medically justified treatment by an authorized clinical dietitian. The insurance covers the number of necessary treatments that can be considered justified for health reasons, up to a maximum of ten treatments per illness/injury and a maximum of ten treatments per calendar year including 1 diet plan per illness/injury. The treatments are distributed in rounds and the Health team will continuously evaluate how many treatments are necessary.

The treatments must, according to our evaluations, lead to a noticeable and lasting improvement in condition, and after a medical evaluation we can refuse to replace treatment of a recurring syndrome/problem. We evaluate whether the insured needs a medical referral.

If diabetes, elevated cholesterol, cardiovascular disease, intestinal coma, uric acid, gluten intolerance or PCO/PCOS are diagnosed during the insurance period, a round of treatment can be covered during the insurance period.

Treatment for underweight can be reimbursed if the insured's BMI (Body Mass Index) is lower than 19, and overweight if the BMI is higher than 30.

4.2.11 Medical rehabilitation after surgery/hospital care

The insurance covers medical rehabilitation for necessary and reasonable outpatient treatment carried out by a physiotherapist, naprapath and/or chiropractor in direct connection with a compensable insurance case in the musculoskeletal system*. The rehabilitation must be prescribed by the treating medical specialist.

Group exercise instructed by a physiotherapist is covered if it is approved by us and is part of a reimbursable rehabilitation plan. Group training is covered with an amount corresponding to the insured's cost of the group training. Chiropractic treatment is covered with an amount corresponding to the insured's cost of general chiropractic care.

4.2.11.1 Medical rehabilitation within our network of private healthcare providers

The insurance covers the number of treatments per illness/injury that, based on a professional and healthcare-related assessment, are deemed necessary and reasonable. The insured will be offered a consultation at a quality-assured clinic and we will settle the payment for the treatment directly with the therapist.

4.2.11.2 Medical rehabilitation outside our network of private healthcare providers

If the insured chooses a physiotherapist, chiropractor or chiropractor without a care agreement who is not part of DSS Hälsa's care network, the customer is covered by SEK 500 per treatment session. The insurance covers the number of treatments per illness/injury that, based on a professional and healthcare-related assessment, are considered necessary and reasonable, for up to 6 months per compensable insurance case from the date of the completed intervention.

The treatments are approved in predefined divisions. If more treatments are needed, the insured must contact our Health team who will evaluate and approve additional treatments.

We may request a status report or treatment plan from the therapist. The payment of the treatment must be made by the insured. When processing is completed, a copy of the original receipts must be sent to us.

4.2.12 Chronic diseases *

The insurance covers the examination and treatment of chronic diseases* and ailments that occur during the insurance period for a period of 6 months from the date of diagnosis, provided that we believe that the treatment will result in a significant and lasting improvement of the condition. Chronic diseases* and ailments that have arisen and/or been diagnosed before the insurance period are not covered by the insurance.

We offer help with all chronic diseases* through advice, guidance through the treatments offered by the public healthcare system, patient rights, information on waiting times, examination and treatment guarantees and help with booking appointments within the public healthcare system.

4.2.12.1 Complications from chronic diseases *

Examination and treatment of complications that arise during the insurance period as a direct consequence of chronic diseases* are covered for up to 6 months from the day the diagnosis is established. In order for compensation to be given, it is required that we believe that the treatment will contribute to a significant and lasting improvement of the condition. Complications that have arisen before the insurance came into effect are not covered.

4.3 Hälsa PREMIUM

In addition to the elements described above under Hälsa BAS and PLUS, the following elements are also included in Hälsa PREMIUM unless otherwise agreed in the group agreement and shown in the insurance statement.

4.3.1 Health examination

The insurance includes a health examination recommended by DSS Hälsa. The examination must be approved in advance and mediated by the Health team. The examination takes place at the supplier referred by the Health team. The insurance covers a maximum of one health examination per year.

4.3.2 Addiction prevention help

The insurance includes a digital prevention anonymous addiction help recommended by DSS Hälsa. The service must be approved and mediated by the Health Team.

4.3.3 Addiction treatment

The policy covers one (1) uninterrupted period of treatment for either alcohol, drug, medication or gambling addiction until the insured has reached the final age to be eligible to join the group agreement.

It is a requirement that there is a medically documented need for the treatment to be covered by the insurance. The insured must therefore contact the Company's healthcare team and follow the procedures that the Company deems necessary to be able to assess the insured's situation. The assessment can be made by specialists within the Company's network or by other suitable suppliers that the Company proposes or approves. The treatment is seen as coverable when the Company has approved the treatment plan proposed by the supplier. The coverage includes the costs that the supplier has had to be able to make an assessment and the subsequent treatment.

The insured has the right to reject one (1) proposed treatment plan for any reason and without any expense or loss of right to coverage. If the insured rejects further treatment plans, he or she will be charged any new assessment costs that may arise in connection therewith. In addition, interruption of ongoing treatment will result in loss of eligibility for additional coverage. Maximum compensation is SEK 100,000 and the Company will inform the insured if the treatment plan is at risk of exceeding the maximum limit.

5 Additional insurance for Hälsa BAS and Hälsa PLUS

Additional insurance only covers mandatorily subscribed group insurance.

5.1 Addiction treatment

The policy covers one (1) uninterrupted period of treatment for either alcohol, drug, medication or gambling addiction until the insured has reached the final age to be eligible to join the group agreement.

It is a requirement that there is a medically documented need for the treatment to be covered by the insurance. The insured must therefore contact the Company's healthcare team and follow the procedures that the Company deems necessary to be able to assess the insured's situation. The assessment can be made by specialists within the Company's network or by other suitable suppliers that the Company proposes or approves. The treatment is seen as coverable when the Company has approved the treatment plan proposed by the supplier. The coverage includes the costs that the supplier has had to be able to make an assessment and the subsequent treatment.

The insured has the right to reject one (1) proposed treatment plan for any reason and without any expense or loss of right to coverage. If the insured rejects further treatment plans, he or she will be charged any new assessment costs that may arise in connection therewith. In addition, interruption of ongoing treatment will result in loss of eligibility for additional coverage. Maximum compensation is SEK 100,000 and the Company will inform the insured if the treatment plan is at risk of exceeding the maximum limit.

5.2 Health examination

The insurance includes a health examination recommended by DSS Hälsa. The examination must be approved in advance and mediated by the Health team. The examination takes place at the supplier referred by the Health team. The insurance covers a maximum of one health examination per year.

6 This is not included in the insurance

6.1 Medical conditions and diagnoses

The insurance does not cover any examination, treatment or other expenses in connection with the following medical conditions and diagnoses:

1. Urgent and acute situations that require prompt assessment and care and cannot wait for planned treatment (i.e. traffic accidents, personal accidents, fractures, blood clots, cerebral hemorrhage, heart disease and other diagnoses that we and/or public health care define as urgent and which require immediate treatment, such as life-threatening cancer or ischemic heart disease If the insured needs emergency medical care, including an ambulance, contact the emergency medical service, the emergency telephone line 112 or 1177.

2. Chronic/permanent illness or condition that has occurred, been symptomatic, diagnosed and/or is known by the insured before the insurance came into effect. Examples of chronic diseases* can be those mentioned below, this does not mean that the chronic diseases are limited to the mentioned diagnoses that are included in this paragraph. Examples type 1 and type 2 diabetes, metabolic conditions, blood diseases, high blood pressure (hypertension), hereditary high cholesterol, atherosclerosis, all types of arthritis and degenerative diseases (arthrosis), spondylosis, bone diseases, connective tissue diseases, hallux valgus, sunken arch, chronic pain , fibromyalgia, Scheuermann's disease, osteoporosis, chronic bronchitis, cystic fibrosis, migraine, epilepsy, Parkinson's disease, whiplash, multiple sclerosis, ALS, peptic ulcer, reflux disease, chronic bowel inflammation, irritable bowel, glaucoma, Ménière's disease, cholesteatoma, endometriosis, menopause, vaginal atrophy, hormonal disorders and the like.

3. Congenital ailments and ailments that can be related to birth/fetal stage and its consequences. This includes but is not limited to hip dysplasia, deformities, hip dislocation and scoliosis. Examination and treatment of asthma, leg length inequality (anisomelia) and dyspraxia are not reimbursed.

4. Anal fissure, anal fistulae and pilonidal cyst.

5. Cosmetic treatments and procedures and their consequences, including conditions considered cosmetic in these terms, such as certain skin conditions, breast augmentation and reduction, problems associated with cosmetic implants, facelifts, drooping eyelids (upper and lower) and gynecomastia. Treatments with Botox and Xiapex are not reimbursed.

6. Discomfort, infections and other effects of implants, tattoos, piercings, prostheses and the like. Complications after treatment/surgery carried out in the private or public healthcare system. Replacement of prostheses and implants that can be carried out in the public healthcare system.

7. Sexually transmitted diseases, HIV/AIDS and its precursors and sequelae. All forms of contraception, including sterilization, IUD insertion and removal, and consequences of these procedures. Examination and treatment of sexual and erectile dysfunction.

8. Fertility, infertility, abortion and consequences thereof. This also includes psychological consequences.

   For examinations, checks, scans and the like in connection with pregnancy and childbirth, the patient is referred to public health care. The health team helps with counseling in the further process.

9. Diseases of the unborn child, colic and colic-like ailments, as well as growing pains and child incontinence.

10. ADHD and subtypes, Asperger's and disorders on the autistic spectrum, dementia, Tourette's syndrome, eating disorders and their consequences.

11. Serious mental illness, e.g. bipolar disorder, personality disorder, schizophrenia, psychosis, PTSD and diagnosed complicated grief. Treatment of diagnosed mental illness that is replaced by public healthcare treatments. Behavioral change treatment by psychologist, such as problems with temperament, infidelity, kleptomania, comfort eating and substance abuse.

12. All types of phobias, such as fear of flying, fear of heights, fear of examinations and social phobia. Treatment of obsessive-compulsive disorder, anxiety resulting from obsessive-compulsive disorder and co-occurring disorders. Recurring cases of panic syndrome, anxiety attacks and general anxiety are not reimbursed.

13. Cardiac arrhythmia, including radiofrequency ablation (RFA), DC conversion and cardiac surgery.

14. Sleep problems, sleep disorders such as sleep apnea and treatment for snoring. Treatment at a sleep clinic.

15. Symptoms after abuse of medicine, alcohol, narcotics or other intoxicants, unless you have taken out additional insurance according to point 5.1.

16. Varicose veins.

17. Fatigue syndrome and hypersensitivity. However, some of these ailments can be compensated to some extent under 4.1.10.

18. Skin conditions that are considered chronic are not reimbursed. These are e.g. benign birthmarks and blemishes, acne, eczema and all types of warts as well as skin damage caused by the sun. No recurring skin diseases or relapses are reimbursed, e.g. elsewhere on the body. Skin cancer is not reimbursed if the disease recurs and requires a new examination and/or treatment.

19. Organ transplantation and consequences of organ transplantation.

20. Hälsa BAS does not include treatment for cancer apart from what is described in section 4.1.5.2 Skin conditions.

6.2 Treatments and forms of treatment

The insurance does not cover expenses for the following examinations, treatments or forms of treatment:

1. Unless otherwise stated in the insurance policy, no preventive and maintenance examinations and treatments, vaccination health examinations, health checks and other preventive checks are included.

2. Couples therapy, parent and family talks, family therapy, coaching, self-development or the like.

3. All types of dental treatment, dental surgery and oral surgery. Orthodontics.

4. Reduced vision and hearing, including amblyopia/strabismus, vision problems, vision correction, vitreous surgery (vitrectomy), glasses, contact lenses and/or vision test, surgery for near- and far-sightedness and structural defects, vision-correcting lenses in connection with cataract surgery, hearing enhancement treatment , hearing aids and hearing tests.

5. Treatment by general practitioners or internal medicine doctors who have not been booked by the company.

6. Examination and treatments which we consider complex and highly specialized and which we believe can best be carried out within public health care. This can e.g. be organ donation and organ transplantation, complex reconstruction, dialysis treatment, gender reassignment surgery, proton therapy and stem cell therapy.

7. Mohs surgery or similar types of treatment.

8. Recreation and treatment stays.

9. Expenses for temporary aids related to outpatient rehabilitation are not reimbursed. Expenses for aids that can be obtained through public care are not reimbursed by the insurance. Orthopedic shoes, CPM machine and the like are not covered by the insurance.

10. Neuropsychology consultations.

11. Dietary treatment for preconceptional health and care, breastfeeding, post-natal weight, sports nutrition, food allergy, intolerance and similar conditions as well as psychological disorders, including stress, depression, eating disorders and overeating.

12. Home help and home health care in cases where the need can be attributed to old age, dementia, senility or the like.

13. Treatment for overweight/obesity* and its consequences in other ways than mentioned under section 4.2.10, including but not limited to gastric bypass, redundant skin surgery after weight loss, or psychological treatment.

14. Back problems if the treating specialist does not consider that the condition can be cured..

6.3 General restrictions

The insurance does not cover the following expenses or claims:

1. Expenses for medical records, certificates, psychological and cognitive tests, medical specialist certificates, referrals from doctors, doctors' recommendations, participation in meetings with municipalities, schools or others when we do not request it in writing.

2. Additional costs due to treatments outside normal working hours are not covered by the insurance (weekend, evening or similar supplements) and additional services such as laser, massage treatment or the like.

3. Additional costs for soles, inserts, bandages, tape, etc.

4. Injuries that occur as a result of or during the practice of professional sports* elite sports (championship-level sports, division 2 or higher), boxing or other striking/kicking martial arts, competition or training at a sports high school, college or other sports-oriented education.

5. Illness/injury that is directly or indirectly self-inflicted due to intoxication, the effects of narcotics, medicine or other intoxicants. Self-inflicted damage that has been caused intentionally or through gross negligence, e.g. fights, suicide attempts, participation in criminal acts. Damages caused by non-compliance with recommendations from healthcare.

6. Injury/illness caused or delayed by war, war-like acts and conditions, including civil war, unrest, insurrection, revolution, terrorism, bacteriological and chemical attacks, nuclear attacks, nuclear energy, radioactive forces, radiation from radioactive waste and fuel, epidemics and pandemics or diseases that fall under the Infection Prevention Act (2004:168).

7. Examination/treatment that is not medically justified or has no proven effect or if the injury, illness or problem is not medically treatable. Growth factor and ornithine therapy, PRF therapy, hyaluronic acid (injections) and modicum changes. No compensation is given for experimental and alternative treatments/therapists such as naturopaths, hypnosis and body therapists other than those mentioned under point 4.15.

8. The insurance does not cover expenses for examination and treatment of illness/injury that occur while traveling or during a stay abroad. Treatment is reimbursed only after the insured returns to his/her permanent residence and based on the general conditions.

9. The insurance does not pay for missed visits or late cancellations with a consultation with a healthcare provider, regardless of whether it concerns medical care, treatment or surgery. The company reserves the right to recover costs from the insured when these situations arise.

10. Travel expenses are not reimbursed for doctors in psychiatry, crisis therapy, hospice and palliative care. Taxi expenses are not reimbursed. Travel costs for healthcare abroad are not reimbursed.

11. Private expenses during hospital stay or similar.

12. Damages that have occurred in connection with the insured having carried out or participated in criminal acts which, according to Swedish law, can result in imprisonment.
13. Compensation from other sources, e.g. due to specific law or constitution, international convention, other insurances or collective agreements.

14. The treatment guarantee does not apply if the insured cannot undergo surgery due to medical reasons, does not participate in the booked treatment, refuses the booked appointment or agrees to postpone the time for the treatment.

15. We are not responsible for the results of any examinations or treatments, even if a treatment is ineffective or results in failure. In such cases, claims should be directed against the clinic or hospital that has performed/performs the treatment.

6.4 Force majeure

The insured cannot assert its rights in these conditions if we are prevented from fulfilling our obligations due to force majeure, such as war, political unrest, law enforcement, pandemics, government or industrial action, or other preventive measures over which we have no control and could not have been prevented if we acted with normal care.

7 If you are not satisfied

7.1 Complaints that are sent to the Company's Insurance Board

If the insured is not satisfied with our decision regarding the submitted claim for compensation, the matter can be tried at our Insurance Board. The complaint must be made within 6 months of the decision.

The application and complaint process is at no cost to the policyholder and the insured, and must be sent to:

Complaints officer
DSS-Hälsa AB
Vasagatan 10, 111 20 Stockholm
or
klagomal@dss-halsa.se

7.2 Public complaint bodies

Depending on the nature of the complaint, compensation issues and insurance disputes can be tried by the following public bodies:

Allmänna reklamationsnämnden (ARN)
Box 174, 101 23 STOCKHOLM

Tel: 08-508 860 00
www.arn.se

Personförsäkringsnämnden (PFN)
Box 24067, 104 50 STOCKHOLM
Tel: 08-522 787 20
www.forsakringsnamnder.se

7.3 Public court

Insurance disputes can always be tried in general court. According to the Insurance Contracts Act (2005:104), the right to bring an action is time-barred ten years after the circumstances that could entitle the insured to compensation or compensation have occurred.

7.4. Independent consultancy

If you want independent advice on general insurance matters, you can contact the Consumers' Insurance Agency:
Konsumenternas Försäkringsbyrå
Box 24215
104 51 STOCKHOLM
Tel: 08-22 58 00
www.konsumenternasforsakringsbyra.se

8 Glossary

Fully workable

"Fully able to work" means that the insured:

- can perform his or her normal work without any restrictions,
- do not receive or have the right to receive benefits from the Swedish social insurance (Försäkringskassan) or any other insurance or receive benefits related to illness or accident from another employer, or
- does not, due to health-related reasons, have specially adapted work, wage subsidies or the equivalent from Swedish or foreign social insurance, employers or insurances.

Compensation from Försäkringskassan refers to sickness or rehabilitation compensation, activity compensation, sickness allowance or other compensation due to incapacity for work.

Completely healthy

Completely healthy means that the child is fully healthy and has no ongoing or planned examination, treatment or check-up for established or suspected health problems.

Chronic disease

Chronic diseases are illnesses, ailments and conditions that our doctors believe are permanent and incurable, and for which there is no curative treatment.

Closest family

Closest family means spouse, registered partner, common-law partner, own children, children of a spouse/partner and adopted children.

The musculoskeletal system

The musculoskeletal system involves tendons, muscles and joints in the back, shoulders, neck, knees, elbows, hips and wrists.

Obesity and overweight

Obesity and overweight means, in these insurance conditions, that the insured has a BMI over 30.

Professional sports

Professional sports means the practice of sports, where the insured receives payment from a sports club or sponsors of more than a current price base amount per year, and where the sport is practiced as a primary activity.

9 Contact information

DSS-Hälsa AB
Vasagatan 10
111 20 Stockholm
www.dss-halsa.se
Organization number: 556751-0424
Switchboard: 08 – 40 00 61 22
Email address: info@dss-halsa.se

Forsikringsselskabet Dansk Sundhedssikring A/S
Hørkær 12B
2730 Herlev
Danmark
https://ds-sundhed.dk/
Organization number: 34 73 93 07
Switchboard: +45 70 20 61 21