ESSENTIALVÅRD+

Insurance Terms and Conditions

Valid from 2021 01 01

DSS Hälsa AB | Torshamnsgatan 20, 164 40 Kista, Sverige | Reg.no. 556751–0424 | Health department: +46 8 4000 6121 | Sales: +46 8 4000 6122 | www.dss-halsa.se

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1 General

1.1 About the insurance

The insurance consists of:

1. The group agreement,
2. the insurance policy with related documents and
3. these terms and conditions.

In case of disagreement between the different parts of the contract, interpretative 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 insurer

The insurer is Squarelife Insurance AG, reg.no. FL-0002.197.228-9. The Board of Directors are located in Liechtenstein. Squarelife Insurance AG is under the supervision of the " Liechtenstein Financial Authority FMA is "Finanzmarktaufsicht Liechtenstein".

The administrator and Swedish representative for this insurance is DSS Hälsa AB org.no. 556751-0424, Torshamnsgatan 20, 164 40 Kista, Sverige. DSS Hälsa AB is under the supervision of Finansinspektionen (FI) the Swedish insurance industry's supervisory authorities.

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 have 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 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 other 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 at another insurance company is transferred as a whole or as a defined group, it is required that all or a minimum of two (2) insured in the defined group is transferred to this insurance.

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In the event of a transfer as described above, the insurance reimburses future treatments reported after the transfer date of this insurance, and it is required that all prescribed treatments are accepted by the Company, including prescribed treatments accepted by the former insurer. Such reported and approved treatment must not be older than six (6) months prior to the transfer date.

If insurance was originally taken out with moratorium of pre-existing condition
the insured will be credited his 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 terms under the current insurance period will be renewed for the next period if not changed by the Company. Information about changes is provided in connection with the premium requirement for the new insurance period.

The Company also has the right to change the terms of the insurance contract during the insurance period if the conditions for the contract change through changed legislation or other statutes, changed legal application or through government regulations.

1.7 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 need 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.

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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.

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 21.

1.8 The Swedish claims register

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

1.9 The 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.

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 final 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 Transfer and pledge

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

2 Who the insurance covers

2.1 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.

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2.3 Requirements

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

- be fully fit for work* (persons not fully fit for work* due to medical reasons are covered, but not any disorder which is the cause for it),
- has turned 16 years old,
- has not reached the age of 67,
- 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.

3 Using the insurance

3.1 How to make a claim

3.1.1 Notification of a claim

In the event of an accident, the insured and/or the policyholder must as soon as possible make a notification by telephone, e-mail or digital solutions to our medical service office in accordance with rules that apply to the insurance element included in the insurance contract.

Anyone claiming compensation must, if we so request, submit medical certificates and other documents that are of importance for determining the right to compensation. The costs for medical certificates and other documents are reimbursed by us 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, Försäkringskassan 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 pre-approved

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 apply to any pre-existing condition, which mean to 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 counted as a new 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 medical treatment, never needed or received any medical advice, received drugs or special diets relating to that condition.

3.4 Choice of treatment and provider

We co-operate with a network of quality-controlled private hospitals and doctors. The insured must use the treatment provider within this network assigned by our medical service office. For certain types of treatment, however, the insured can choose a doctor outside our network.

We only approve treatments using methods with a documented effect and approved by the public health authorities in Sweden. In addition it is a prerequisite that the treatment is available in Sweden within the public healthcare or our network of private medical providers.

3.5 Examination and treatment guarantee

The insured is guaranteed that a coverable examination and/or treatment will occur within 7 working days at a doctor in the private or public healthcare system after we have approved the examination/treatment.

For an insurance event that requires surgery/hospitalization the insurance guarantees the insured's right to surgery within 14 working days.

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

If we are unable to fulfill the treatment guarantee, an amount of SEK 500 will be paid to the insured per working day. Compensation is paid from the working day following the guaranteed day and until the insured receives the guaranteed treatment, and in any case at a total maximum of a year’s premium for the insured.

If the treatment consists of multiple approved and planned hospitalizations, the guarantee applies only to the first consultation. If an examination/ treatment must be delayed for medical reasons or if the insured does not accept the proposed time, the treatment guarantee does not apply. The treatment guarantee applies to healthcare available in the private or public care sector in Sweden.

3.6 Annual maximum insurance cover

The maximum annual cover and reimbursement per insured will be stated in the insurance policy.

3.7 Deductible

Any deductible will be stated in the insurance policy.

3.8 Period of limitation

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.

3.9 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 What the insurance covers

4.1 Expenses for treatment

The insurance covers your patient fees for public care, including emergency care, and up to any applicable high-cost protection (högkostnadsskydd).

In cases where we designate a private clinic or private hospital for treatment, the payment will be directly settled between the private medical provider and us. We do not cover expenses that the public sector has already fully or partially covered or expenses which the public sector has offered to cover.

Approved claims expenses are limited to necessary and reasonable costs in the region where the treatment is provided.

4.2 HealthNavigator

Our medical service office assists the insured with medical advice from registered nurses by telephone via +46 8 – 40 00 61 21, DSS Hälsa's app, e-mail or the website. Our dedicated healthcare team has many years

of experience from various areas of specialization and they offer professional advice on all health problems including those that do not require actual treatment, or which are not covered by the insurance.

Through our unique HealthNavigator concept we also provide advice about the public healthcare system's treatment options, e.g. patient rights, appeal procedures, guidance about waiting times, how to approach local public health centers (vårdcentraler) or how to benefit from the free choice of public hospital options. All examination and public treatment alternatives within the primary care included. We also help to review medical records from hospitals and doctors, or other assistance if necessary.

In cases where the injury can only be handled in the public sector or is not covered by the insurance, we offer to provide the insured with advice regarding the course of treatment in the public health service.

4.3 Chronic diseases*

The insurance covers examinations and treatment of chronic diseases* and disorders that arise during the insurance period for up to 6 months from the date of diagnosis, if we consider that treatment will result in a significant and lasting improvement of the condition. Chronic diseases* and disorders that have occurred and/or are diagnosed before the insurance period, are not covered.

We offer assistance for all chronic diseases* through counselling, guidance on the public health system's treatment offers, patient rights, waiting times, examination and treatment guarantees and help with booking appointments in the public healthcare system.

4.3.1 Complications from chronic diseases*

Examination and treatment of complications that arise during the insurance period as a direct consequence of a chronic disease*, are covered for up to 6 months from the date of diagnosis. It is a prerequisite for coverage that we consider that treatment will cause a significant and lasting improvement to the condition. Complications that occurred before the insurance came into force are not covered.

4.4 Pain diagnosis

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

4.5 Medical doctors

The insurance covers necessary and reasonable examination, treatment/surgery of a covered disease/injury carried out by a relevant medical doctor designated by us.

The examination may contain imaging diagnostics and tests that are necessary and relevant for establishing a diagnosis. A referral must be issued by a medical doctor or licensed therapist.

The examination and treatment should primarily be performed by a medical doctor as close as possible to the insured's place of residence in Sweden.

The examination/treatment/surgery may be handled by a medical doctor in the public healthcare system, from a chosen digital medical doctor or by a medical doctor within a private clinic or hospital.

4.5.1 Skin conditions

The insurance covers treatment of skin conditions which we consider affect the insured's health condition. We always help with advice, navigation in the public healthcare system and helps with booking appointments for all skin conditions.

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

4.5.2 Allergy diagnosis

The insurance covers an examination to determine allergy diagnosis. The examination will be after prescription by doctor and approved by us.

4.5.3 Psychiatrist

The insurance covers necessary and reasonable costs for treatment by a psychiatrist. It is a prerequisite for cover that there is a medical need to receive treatment and that the treatment ensures progression/improvement of the condition.

4.6 Digital health service

The insurance covers digital healthcare treatments and/or counselling by telephone or video with a nurse, physiotherapist, psychologist or medical doctor.

4.7 Follow-up examinations

The insurance covers necessary and reasonable outpatient follow-up examination after surgery covered by the insurance for up to 6 months from the date of the surgery. The examination must be prescribed by the relevant medical doctor and approved by us.

4.8 Medical rehabilitation after surgery/hospitalization

The insurance covers outpatient medical rehabilitation performed by a physiotherapist, naprapathy and/or chiropractor in direct connection to a coverable procedure in the musculoskeletal system*. The rehabilitation must be prescribed by the attending medical doctor.

Treatment by physiotherapist or use of a therapist with public health insurance agreement require a referral.

Team training instructed by a physiotherapist is covered if it is part of a covered course of rehabilitation and is approved by us. Team training is covered with the amount corresponding to the patient's share for team training. For chiropractic treatment, the amount corresponding to the patient's share is covered according to the rate applicable for general chiropractic.

4.8.1 Medical rehabilitation in the preferred provider network

The insurance covers the necessary and reasonable number of treatments per claim (disease/injury) based on a professional healthcare assessment. Insured will be offered a quick appointment at a quality-assured clinic and we will settle directly with the therapist.

4.8.2 Medical rehabilitation outside the preferred provider network

The insurance covers a necessary and reasonable number of treatments by a physiotherapist or chiropractor for up to 6 months per claim (illness/injury) calculated from the date of the prescribed procedure.

The treatments are allocated in pre-defined portions. If more treatments are needed, the insured needs to contact our medical service office, who will evaluate and allocate additional treatments.

We may request a status report or treatment plan from the therapist. Payments of treatment must be settled by the insured. When treatment is completed a copy of all the original bills must be sent to us.

4.9 Home assistance

The insurance covers necessary and reasonable expenses for temporary home assistance in a direct connection with an operation covered by the insurance. The temporary home assistance or home nursing must be prescribed by the attending medical doctor and pre-approved by us.

Temporary help for cleaning, shopping, personal hygiene and dressing/undressing is covered for a maximum of 14 days from the date of discharge from the hospital/clinic, and a maximum of 20 hours in all including travel time.

4.10 Prescribed medicine

The insurance covers necessary and reasonable expenses of prescription medicines in connection with a coverable procedure or treatment. The medicine must be prescribed by the attending medical doctor and be necessary for the medical procedure performed. Medicine expenses are covered up to 6 months from the date of the prescription. We cover prescribed medicine that is not available over the counter.

4.11 Transport expenses

The insurance covers necessary and reasonable transport costs between the insured's place of residence and the hospital/clinic public or private when the total trip is at least 100 kilometers, return trip included.

The payment per kilometer is equal to the public rate of Skatteverket at any time.

The transport cost must be pre-approved by us.

4.12 Physiotherapist, naprapat, chiropractor and osteopath

The insurance covers necessary and reasonable costs for treatment by a physiotherapist, naprapath, chiropractor and osteopath. It is a prerequisite for cover that there is a medical need to receive treatment and that the treatment ensures progression/improvement of the condition.

Based on a medical assessment, we will assign the insured to the relevant treatment. To ensure the correct treatment, we will continuously assess how many treatments are needed and whether the insured receive the correct treatment.

If an insured chooses a provider without an agreement with the public healthcare system, the insurance covers the amount equal to local customary provider rates.

4.13 Psychologist/psychotherapist

The insurance covers necessary and reasonable treatments by a licensed psychologist or psychotherapist, if we consider that it is possible to achieve a significant and lasting improvement in the state of health. Cover may require a referral from a doctor unless we decide that an applicable treatment within our preferred provider network is preferable. We will continuously assess how many treatments the insured needs and whether the treatment is appropriate. It is a prerequisite for cover that there is a medical need to receive treatment and that the treatment ensures progression/improvement of the condition.

In the case of treatment by a psychologist/psychotherapist without an agreement with the public healthcare system, the insurance covers the amount equal to local customary provider rates.

4.14 Trauma counselling

The insurance covers emergency trauma counselling if we consider that the insured has experienced an acute psychological crisis due to one of the following:

1. If the insured have experienced a sudden serious incident/accident, where the insured has been in danger,
2. if the insured is subjected to a robbery, assault, violence or kidnapping,
3. fire, explosion or burglary in the insured's private residence or business (must be reported to the police),
4. if the insured is diagnosed with a life-threatening disease,
5. death within the insured's immediate family*,
6. if a member of the insured's immediate family* is diagnosed with a life-threatening disease, or
7. if the insured experiences a family member's or colleague's sudden, unexpected death or sudden serious incident/accident.

There is no requirement for a doctor's referral. We assess whether emergency trauma counselling is required or whether other treatment is required.

If we consider that the insured is in need of emergency trauma counselling, we will find a psychologist for the insured in our network. The subsequent process will depend on the nature of the incident and the therapist's professional assessment.

In case of notification more than 48 hours after the cause of the crisis, cover for ordinary psychological counselling will always apply. Debriefing is only covered as part of an approved emergency course of treatment.

4.15 Hotline for well-being

Telephone counselling regarding well-being issues is available for the insured through our quality assured network of psychologists, psychotherapists or other health professionals. Need for counselling can arise through different affecting causes such as private issues with relations, lifestyle, addiction or stress, or work-related issues with burnout, dismissal, bullying and conflicts. There could also arise a need for professional coaching when being a manager.

Our service is available weekdays in office hours and all treatments will be arranged by us. Counselling will be accessed within 2 working days and the cover is provided for a maximum 5 conversations of 60 minutes each per course. The number of treatments is decided based on the counselor's professional assessment.

4.16 Dietician

The insurance covers medically justified treatment by authorized clinical dietician. Cover is provided for the number of necessary treatments that can be justified for healthcare reasons, up to a maximum of 10 treatments per disease/injury and a maximum of 10 treatments per calendar year including 1 dietary plan per disease/injury. The treatments are allocated in portions and the healthcare team will continuously assess how many treatments are necessary.

The treatments shall, according to our evaluation, lead to a significant and permanent improvement in the condition, and after a medical assessment we may refuse to cover treatment of a recurring disorder/problem. We assess whether the insured needs a written medical referral.

If diabetes, elevated cholesterol, cardiovascular disease, bowel disorder, uric acid, coeliac disease or PCO/PCOS are diagnosed during the insurance period, 1 course of treatment can be covered during the insurance period.

Treatment of underweight can be covered if insured's BMI (Body Mass Index) is less than 19, and overweight if the BMI is over 30.

4.17 Acupuncture/zone therapy

The insurance covers necessary and reasonable costs for treatment with acupuncture or zone therapy. Treatment is covered up to a maximum of 10 sessions per diagnosis/accident. It is a prerequisite for cover that there is a medically documented need to receive treatment and that the treatment ensures progression/improvement of the condition. It is an additional prerequisite for acupuncture that the underlying condition is on the World Health Organisation's (WHO) list of conditions where acupuncture has a positive effect.

Based on a medical assessment, we will assign the insured to the relevant treatment. To ensure the correct treatment, we will continuously assess how many treatments are needed and whether the insured receive the correct treatment.

If an insured chooses a provider without an agreement with the public healthcare system, the insurance covers the amount equal to local customary provider rates.

4.18 Temporary aids

The insurance covers expenses for personal temporary aids, which we consider necessary and reasonable in connection with a coverable procedure or treatment. The aid must be prescribed by the attending medical doctor. Temporary aids, including hired aids, are covered for a maximum of 6 months.

4.19 Second/third opinion

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

- Have a life-threatening or particular serious disease or injury.
- Is faced with the choice of receiving particularly risky treatment, which may be life-threatening or result in permanent injury.

If we consider that the insured is entitled to a second opinion, a medical doctor will revert to the insured from either a public or a private healthcare provider, digitally or via physical examinations. If the insured is facing a difficult decision or if there is uncertainty regarding a diagnosis or type of treatment, we offer advisory consultation with dedicated doctors and nurses. If the two doctors disagree on a diagnosis or type of treatment we offer a third opinion via telephone.

5 Optional covers

5.1 Addiction treatment

The insurance covers one (1) uninterrupted period of treatment of either alcohol-, drug-, medicine- or gambling addiction until the insured has reached the final age of inclusion under the group agreement.

It is a prerequisite for cover that there is a medical need to receive treatment. The insured must therefore contact the Company's medical service office and follow any procedure suggested by the Company for assessing the insured's situation. Assessment can be made by specialists in the Company's network or by other suitable providers which the Company suggests or approves. Coverage will be given when the Company has approved the treatment plan suggested by the provider. Coverage includes costs for the provider's assessment and the following treatment.
The insured has the right to reject one (1) suggested treatment plan regardless of reason, and without any costs or loss of right to cover. If the insured rejects further treatment plans, he or she will be charged any new assessment costs that might occur in connection with this. Further on and if not agreed otherwise, any interrupted ongoing treatment will result in a loss of right to further coverage.

Maximum coverage is 100 000 kr and the Company will inform the insured if the treatment plan is in risk of exceeding the maximum coverage.

6 What the insurance does not cover

6.1 Medical conditions and diagnoses

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

1. Emergency and acute situations that require rapid assistance and cannot await scheduled treatment (e.g. traffic accidents, personal accidents, fractures, blood clots, brain hemorrhage, heart disease and other diagnosis areas that we and/or the public sector define as acute and which require immediate treatment, such as life-threatening cancer and ischemic heart disease) as well as cancer treatment packages. If the insured needs emergency care, including ambulance, contact the emergency medical service, the emergency telephone line 112 or 1177.

2. Chronic/permanent diseases and disorders that have occurred, been symptomatic, diagnosed and/or known by the insured before the insurance came into force. Chronic diseases* include but

are not limited to type 1 and type 2 diabetes, metabolic disorders, blood disorders, hypertension, hereditary cholesterol elevation, atherosclerosis, all types of arthritis and degenerative disorders (osteoarthritis), spondylosis, bone diseases, connective tissue disorders, bunions, fallen arches, chronic pain, fibromyalgia, Scheuermann's disease, bone morbidity, chronic bronchitis, cystic fibrosis, migraine, epilepsy, Parkinson's disease, whiplash, multiple sclerosis, ALS, gastric ulcer, reflux, chronic intestinal inflammation, irritated colon, glaucoma, Ménière's disease, cholesteatoma, endometriosis, menopause problems, vaginal atrophy, hormonal disorders and similar.

3. Congenital disorders and disorders that may be related to the birth/foetal 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 covered.

4. Anal fissure, anal fistulae and pilonidal cysts.

5. Cosmetic treatments and procedures and their consequences, including disorders that are considered cosmetic in these conditions, e.g. some skin diseases, breast enlargement and reduction surgery, breast reconstruction, problems associated with cosmetic implants, face lifts, hanging eyelids (lower and upper) and gynecomastia. Treatments with Botox and Xiapex are not covered.

6. All kinds of warts, benign birthmarks and spots, lipomas, acne, eczema, psoriasis, vitiligo, rosacea, skin damage, skin transplants, actinic and seborrheic keratosis and similar skin disorders.

7. Discomforts, infection and other effects of implants, tattoos, piercings, prostheses and similar. Complications after treatment/surgery undertaken in the public or private healthcare system. Replacement of prostheses and implants that can be performed in the public system.

8. Sexually transmitted diseases, HIV/AIDS and its precursors and consequential diseases. All forms of contraception, including sterilization, deployment and removal of IUDs, and consequences of these procedures. Examination and treatment of sexual and erectile dysfunction.

9. Examination, treatment and checkup of fertility, infertility, abortion and their consequences. This also applies to psychological consequences, except for treatment by a psychologist referred by a doctor for postnatal reaction, postnatal depression and problems following late-term abortion, which are covered in cases where we consider that treatment may permanently improve your health. Relapse is not covered. For examination, checkup, scanning and similar in connection with pregnancy and childbirth, we refer to the public offers. We help with advice in the further process.

10. Diseases in the unborn child. Colic pain and colic-like conditions in children, as well as growing pains and child incontinence.

11. ADHD with subtypes, Asperger's and disorders on the autism spectrum, dementia, Tourette's syndrome, eating disorders and their consequences.

12. Severe mental illness, e.g. bipolar disorder, personality disorders, schizophrenia, psychoses, PTSD and diagnosed complicated grief. Treatment of diagnosed mental illnesses that are covered by the public treatment packages. Behavior modification treatment by a psychologist, such as problems with temper, infidelity, kleptomania, comfort eating and addiction.

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13. All kinds of phobias, such as fear of flying, fear of heights, exam anxiety and social phobia. Treatment of OCD, anxiety due to OCD and consequential conditions. Recurring instances of panic disorder, anxiety attacks and generalized anxiety are not covered.

14. Cardiac arrhythmia, including radio frequency ablation (RFA), DC conversion and cardiac surgery.

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

16. Symptoms of abuse of medicine, alcohol, narcotics or other intoxicants, except if covered under optional cover 5.1.

17. Varicose veins (varices).

18. Fatigue syndrome, hypersensitivity, stress reactions and burnout. However, some of these conditions might be covered to a certain extent under 4.15.

19. Skin diseases that are considered as chronic are not covered. These are e.g. benign birthmarks and spots, acne, eczema and all kinds of warts and damage caused to the skin by the sun. No recurrent skin disorders or relapses are covered, e.g. elsewhere on the body. Skin cancer is not covered in the event that the disease returns and requires new examination and/or treatment.

20. Organ transplants or consequences of organ transplants.

6.2 Treatments and forms of treatment

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

1. Preventative and maintenance examination and treatment, vaccinations, health examinations, health checks and other preventive controls.

2. Couple therapy, parenting and family conversations, family therapy, coaching, self-development and similar.

3. All types of dental treatment, dental surgery and oral surgery. Bite plates.

4. Impaired vision and hearing, including squinting, binocular vision problems, sight correction, vitrectomy, glasses, contact lenses and/or sight test, surgery for near and long-sightedness and structural defects, sight-correcting lenses in connection with surgery for cataracts, hearing-enhancing treatment, hearing aids and hearing tests.

5. Consultations with a general practitioner, general medicine doctor or foreign doctors that can be considered as equivalent.

6. Examination and treatment which we regard as complex and highly specialized, and which we consider can best be performed in the public health service. This could be e.g. organ donation and organ transplantation, complex reconstruction (including grade 3 and 4 ruptures), surgery for rectus diastasis, dialysis treatment, sex change operation, proton therapy and stem cell treatment.

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7. Mohs surgery or similar types of treatment.

8. Recreational and treatment stays.

9. Expenses for temporary aids related to outpatient rehabilitation are not covered. Expenses for aids that can be received through the public services are not covered by the insurance. Orthopedic footwear, a CPM machine and similar are not covered.

10. Neuropsychologist consultations.

11. Dietary treatment for preconception care, lactation, sports nutrition, food allergy, intolerance and similar conditions, as well as psychological disorders, including stress, depression, eating disorders and overeating.

12. Home assistance and home nursing in those cases where the need can be attributed to old age, dementia, senility or similar.

13. Overweight/obesity* treatment and its consequences in any other way than mentioned under section 4.16, including but not limited to gastric bypass, excess skin surgery after weight loss, or psychological treatment.

14. Back problems if the treating doctor evaluates that it is not curable.

6.3 General limitations

The insurance does not cover the following expenses or injuries if occurring or caused by the following reasons:

1. Expenses for medical records, certificates, psychological and cognitive tests, medical doctor certificates, doctor's referrals, doctor's recommendations, participation in meetings with municipalities, schools and others when not requested by us in writing.

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

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

4. Injuries that occur as a result of or during the performance of professional sports*, elite sports (championship level sports, division 2 or higher), boxing or other martial arts with punches/kicks, competition or training at sports gymnasium, college or other education with sports orientation.

5. Disease/injury that is directly or indirectly self-inflicted due to intoxication, the effects of narcotics, medicine or other intoxicants. Self-inflicted injury caused intentionally or through gross negligence, e.g. fights, attempted suicide, participation in criminal offences. Injuries caused by non-compliance with healthcare recommendations.

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6. Injury/disease caused by or delayed by war, warlike acts and conditions, including civil war, civil unrest, rebellion, revolution, terrorism, bacteriological and chemical attacks, nuclear reactions, nuclear energy, radioactive forces, radiation from radioactive fuel and waste, epidemics and pandemics, or diseases covered by The Communicable Diseases Act (smittskyddslagen) (2004:168).

7. Examination/treatment that is not medically justified or has no proven effect or the injury, illness or inconvenience is not medically treatable. Growth factor and ornithine treatment, PRF treatment, hyaluronic acid (injections) and modic changes. No cover is provided for experimental and alternative treatments/therapists such as natural healers, hypnotists, and body therapists other than mentioned under 4.17.

8. The insurance does not cover expenses for examination and treatment of a disease/injury that occurs during travel or during a stay abroad. Treatment will only be covered after the insured returns home to his or her permanent residence and based on the general condition.

9. The insurance does not pay for examination/treatment that the insured fails to attend, nor do we pay for charges due to late cancellation, regardless of whether it is medical care, treatment or surgery. Such treatment will be invoiced the insured persons.

10. Transport expenses are not covered for medical doctors in psychiatry, emergency trauma counselling, hospice and terminal care. Expenses for taxis are not covered. Transport expenses for medical doctor care abroad are not covered.

11. Private expenses during hospitalization or similar.

12. Injuries that have arisen in connection with the insured having performed or participated in a criminal act which under Swedish law may result in imprisonment.

13. Compensation from elsewhere, for example due to special law or constitution, international convention, other insurance or collective agreements.

14. The treatment guarantee does not apply if the insured cannot be operated for medical reasons, is absent from booked treatment, declines the booked time or agree on later booked time for treatment.

15. We are not responsible for the result of any examinations or treatments, even if a treatment is ineffective or results in errors. In such cases, claims should be made against the clinics or hospitals carrying out the treatment.

6.4 Force majeure

The insured cannot assert his rights under these terms and conditions if we are prevented from fulfilling our duties due to force major, such as war, political unrest, law enforcement, government action or industrial action, or other obstructing events of which we do not have any control over or couldn't have prevented if we acted with normal care.

7 If you are dissatisfied

7.1 Complaints submitted to the Company's Insurance Board

In case the insured is not satisfied with our decision on the submitted claim the matter can be tried in our insurance board. The complaint must be made within 6 months after the decision.

The application and the complaints process is free of charge for the policyholder and the insured, and shall be sent to:

Klagomålsansvarig/Complaints responsible
DSS Hälsa AB
Torshamngatan 20. 164 40 Kista, Sverige
or
klagomalsansvarig@dsshalsa.se

7.2 Public complaints offices

Depending on the complaint's nature, compensation issues and insurance disputes may be tried by the following general boards:

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 General court

Insurance disputes can always be tried in a general court. According to the Insurance Contracts Act (2005:104), the right to bring an action ceases after ten years from the time when the circumstance occurred that could entitle the insured to a compensation or cover.

7.4. Independent advice

If you want independent advice on general insurance issues, you can contact the Konsumenternas Försäkringsbyrå (Consumers' Insurance Bureau):

Konsumenternas Försäkringsbyrå
Box 24215
104 51 STOCKHOLM
Tel: 08-22 58 00
www.konsumenternasforsakringsbyra.se

Glossary

Fully fit for work

With “fully fit for work" means that the insured

- can perform his or her normal work without any restrictions,
- does not receive or is entitled to receive benefits from the Swedish social security (“Försäkringskassan”) or any other insurance or receive contributions related to illness or accidents from employers, or
- has not, for health reasons, specially adapted work, wage subsidy employment or the equivalent from Swedish or foreign social insurance, employer or insurance.

Compensation from the “Försäkringskassan” refers to illness or rehabilitation allowance, activity compensation, sickness benefit or other compensation due to incapacity.

Completely healthy

By being completely healthy means that the child is fully healthy and has no ongoing or planned examination, treatment or control for diagnosed or suspected health problems.

Chronic diseases

Chronic diseases are diseases, conditions and disorders that our doctors consider are persistent and cannot be cured, and where there is no curative treatment.

Immediate family

Immediate family members refer to a spouse, registered partner, cohabitant, own children, a spouse’s/cohabitant’s children and adopted children.

Musculoskeletal system

The musculoskeletal system means tendons, muscles and joints of the back, shoulders, neck, knees, elbows, hip and wrists.

Obesity and overweight

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

Professional sport

Professional sport means the practice of sport, where the insured receive payment from a sports club or sponsors of more than one price base amount (prisbasbelopp) per year, and where the sport is practiced as a primary business.

Contact information

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