DKV Hälsa Healthcare Insurance

GUIDE AND TERMS OF INSURANCE

- FOR INDIVIDUAL AND COLLECTIVE INSURANCE AGREEMENTS

OSLO, JANUARY, 2018

About this booklet

This booklet contains all the terms that apply to your insurance, including terms of insurance that can be agreed upon with DKV Hälsa.

DKV Hälsa refers to Storebrand Helseforsikring AS Norway branch, Vasagatan 10, S-105 39 Stockholm, telephone +46 8 619 62 00, www.dkvhalsa.se, C.I.N. 516402-6998, registered in the branch register Filialregistret.

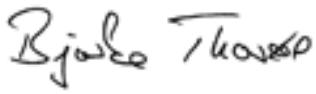
DKV Hälsa sells insurance for Storebrand Helseforsikring AS, Professor Kohts vei 9, Postbox 464, N-1327 Lysaker, telephone +47 22 31 13 30, www.storebrand.no/helse, C.I.N. 980 126 196, registered in the company register Foretaksregistret, Brönnöysund.

Good advice: Read through the insurance policy and terms carefully.

We suggest that you store the insurance documents in a place where you can quickly find them if needed. You can also download our app DKV Hälsa via App Store or Google Play. Once you have registered you have easy access to your terms of insurance. Using the app you can, for example, make a healthcare appointment or apply for compensation for treatment costs.

If you have any questions that you cannot find the answers to, we hope that you will contact us so we can help you.

Write to admin@dkvhalsa.se or call 08-619 62 00.



Sincerely
Bjarke Thorøe CEO
DKV Hälsa/ Storebrand Helseforsikring AS

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How you use your insurance

You are covered either by individual insurance that applies to an individual person and which involves individual terms (individual insurance) or as a member of a collective insurance agreement that applies to people in a defined group (group insurance).

Your rights and obligations in relation to these terms will depend on whether you are covered by individual insurance or a group insurance policy. It is important that you refer to the provisions that apply to your insurance; your insurance policy states whether you have individual insurance or a group insurance.

Insurance elements

The insurance policy shows the elements included in your insurance. The terms that apply to your insurance are set out using term numbers stated in the insurance policy. If you are unsure of the elements included in your insurance, you are welcome to contact us.

Helpline

When you require healthcare, call our Helpline at 0770 456 780, which is manned by licensed nurses. Helpline cab assist you in making an appointment for the healthcare, examination or treatment you require. You and a nurse from Helpline agree on a time and place for your care provision. If you need to cancel an appointment, you must do so no later than 24 hours before the agreed consultation; cancellation needs to be done on a weekday (not a public holiday) cannot be done by e-mail.

Helpline
0770-456 780

Based on the scope of your insurance (as indicated in the insurance policy and terms), you can use the insurance as follows:

Hospitalisation and day surgery

If you are referred for hospitalisation with an overnight stay for surgery or treatment, for cancer treatment or for day surgery, please send a copy of the referral to DKV Hälsa. Helpline will then help you find relevant private hospitals or specialists to choose from. Helpline will contact you after talking with the hospital and/or specialist and agree on a time for hospitalisation and/or treatment. We then send written confirmation and approval to the hospital or specialist indicating that we will cover the cost of the hospitalisation and/or treatment, and a copy is also sent to you.

Treatment that is to be paid for via the insurance must be pre-approved by Helpline. This ensures fast and qualitative access to care and treatment. DKV Hälsa pays the healthcare provider directly.

Public healthcare

For patient fees within public healthcare, compensation is provided up to the high-cost protection level. If you have a referral requirement in your insurance, we will cover treatment with a referral from a doctor. Your insurance policy indicates if you have a referral requirement.

Referral management

If you get a referral to a specialist, psychologist, physiotherapist, naprapath or chiropractor, contact Helpline for assistance in making an appointment with a specialist or clinic.

All treatment must be pre-approved by Helpline.

If you make the appointment on your own, you need to pay for the visit/treatment yourself. You must then submit the original receipts together with a completed insurance claim and any referral or copy thereof no later than 12 months after the scheduled appointment/treatment.

The easiest way to submit an insurance claim is via our mobile app “DKV Hälsa”. Using the app you can easily take a photo of the receipt or referral and send it. It is also possible to fill in an insurance claim via our website www.dkvhalsa.se. All information in the insurance claim needs to be filled in.

The easiest way to submit an insurance claim is via our mobile app “DKV Hälsa”

Travel and subsistence costs

The insurance reimburses necessary and reasonable costs for travel in connection with specialist medical treatment/examination. Travel expenses are reimbursed if the distance between the home and the treatment facility is greater than 150 km one way. If you drive your own car, mileage allowance will be paid according to the Swedish Tax Agency’s rules for mileage allowance, provided that the trip is pre-approved by the insurer.

The insurance covers travel and subsistence costs in conjunction with hospitalisation and/or surgery. The insurance covers necessary and reasonable travel and subsistence costs for an adult companion in connection with hospitalisation and surgery when the insured party is under the age of 18 and/or when medically necessary. Expenses that are to be covered by the insurer must be pre-approved by Helpline. Subsistence costs are reimbursed according to the Swedish Tax Agency’s rules for food and accommodation. If you are unsure of the elements included in your insurance, please contact the insurer.

The insurer's liability requires

- that the insurance covers the treatment in question. This is indicated in the insurance policy and the general and specific terms and conditions
- that the insured party has provided accurate and complete
- health-related information
- that the insurance is paid and in force

Overview of services and costs that can be reimbursed by the insurance

Costs for surgery on a bodily illness at a private hospital, which requires an overnight stay at a hospital, following referral from a doctor and which is pre-approved by the insurer	Reimbursed
Costs for surgery on a bodily illness at a private hospital, which requires an overnight stay at a hospital, following referral from a doctor and which is pre-approved by the insurer	Reimbursed
Costs for surgery at a private hospital, which does not require an overnight stay at a hospital (day surgery), following referral from a doctor and which is pre-approved by the insurer	Reimbursed
Treatment, examination and diagnosis of a bodily illness by a general practitioner or specialist. Must be pre-approved by the insurer. May require a referral if indicated in the insurance policy	Reimbursed
Cancer treatment, e.g. surgery, radiotherapy and chemotherapy, after referral and pre-approved by the insurer	Reimbursed
Consultation with a medical specialist for further assessment, Second opinion. One per diagnosis and only in the case of critical illness and/or particularly risky treatment. Must be pre-approved by the insurer	Reimbursed
Necessary examinations, tests and samples at the hospital/clinic in direct and immediate connection with the surgery/treatment	Reimbursed
Necessary drugs and material used during the surgery/treatment at the hospital/clinic/medical specialist	Reimbursed
Necessary medical devices that are an integral part of the body (prostheses, implants).	Reimbursed
Necessary and reasonable subsistence costs (food and accommodation) in connection with hospitalisation and during surgery (does not apply to specialist medical treatment and physical therapy). Subsistence costs are reimbursed according to the Swedish Tax Agency's rules on food and accommodation, and must be pre-approved by the insurer	Reimbursed
Necessary travel expenses for the insured party in connection with hospitalisation/surgery/cancer treatment and/or rehabilitation (does not apply to physical therapy). In the event of specialist medical treatment, travel allowance is paid if the distance between the insured party's home and the treatment facility is greater than 150 km, one way. The journey must be pre-approved by the insurer	Reimbursed
Rehabilitation of up to 28 days at a rehabilitation institution in the Nordic countries. The rehabilitation must be a necessary consequence of a necessary part of the surgery/hospitalisation, following referral from a doctor, and must be pre-approved by the insurer.	Reimbursed
The treatment guarantee during hospitalisation is 14 working days from the date when the insurer receives complete and necessary medical documentation	Reimbursed
The treatment guarantee during hospitalisation is 14 working days from the date when the insurer receives complete and necessary medical documentation	Reimbursed
Physical therapy of a bodily illness. I.e., expenses for treatment by a licensed physiotherapist, chiropractor or naprapath after referral from a doctor; up to 24 treatments per calendar year. Must be pre-approved by the insurer	Reimbursed if indicated in the insurance policy
Crisis support. Up to 10 treatments per incident. Must be pre-approved by the insurer	Reimbursed
Cost of treatment by a psychologist/psychotherapist stage II, for mild mental disorders, up to 10 treatments per insurance case. The treatment may be required to be referred by a doctor and must be pre-approved by the insurer	Reimbursed if indicated in the insurance policy
This is a simplified overview. For complete information, see the general and specific terms and conditions.	

General Terms and Conditions

(It is indicated in the insurance policy if you adhere to no. 13.00.01 or 13.00.02)

1. Insurance Agreement

The insurer is Storebrand Helseforsikring AS, C.I.N. 980 126 196 in Foretaksregistret, Brønnøysund, Norway, address Professor Kohts vei 9, Postbox 464, N-1327 Lysaker, Norway. The insurer is represented in Sweden by Storebrand Helseforsikring AS Norway, branch office in Sweden, C.I.N. 516402-6998, Vasagatan 10, S-105 39 Stockholm, with trade name DKV Hälsa.

1.1. The insurance agreement is subject to

- the Swedish Insurance Contracts Act (2005:104)
- the Swedish Insurance Act (2010:2043) and regulations
- the Act (1998:293) on the Undertakings of Foreign Insurers and Institutions for Occupational Retirement in Sweden
- Other legal provisions and those issued pursuant to Swedish law

The insurance agreement is pursuant to Swedish law and drawn up in the Swedish language, unless otherwise agreed.

1.2. What insurance provisions apply

The insurance agreement is subject to these general terms of insurance and the specific terms, as indicated in the insurance policy. The text of the insurance policy takes precedence over the general terms of insurance and the specific terms. The text of the specific terms takes precedence over the general terms of insurance. The insurance policy, the specific terms of insurance, the general terms of insurance and any other agreement between the parties take precedence over such provisions of law or other provisions issued pursuant to law that are not compulsory in nature.

1.3. Definitions and explanations

See definitions and explanations at the end of this condition.

1.4. Who is covered by the insurance

1.4.1. Individual insurance agreement (General terms no. 13.00.01)

An individual insurance agreement can only be signed for a person who is residing in the Nordic region and who is affiliated with and entitled to compensation from a social insurance body in the Nordic countries. Insurance can be taken out between the ages of 0 and 66 (the application must be received by the company no later than the day before the applicant turns 67). The insurance can apply throughout the insured party's lifetime if it does not cease to be valid at an earlier date for some other reason.

1.4.2. Collective insurance agreement (General terms no. 13.00.02)

A collective insurance agreement can only be signed for persons who are residing in the Nordic region and who are affiliated with and entitled to compensation from a social insurance body in the Nordic countries. Insurance can be taken out between the ages of 16 and 66. The insurance ceases to be valid during the insurance year in which the insured party turns 72 years old, unless the insurance has previously ceased to be valid for some other reason.
Sports associations or sports teams, as a group, cannot take out insurance, neither as mandatory nor optional coverage.
In the case of a collective insurance agreement, the individual insured party may opt out of being covered by the insurance, and DKV Hälsa shall be notified by written confirmation of which person/s are opting out. If the person wishes to join the agreement at a later date, individual conditions with a health declaration apply.

1.4.3. Co-insured through an employee

An employee who is connected to a collective insurance agreement can also insure their spouse/commonlaw spouse and children. Agreements for co-insured parties can only be signed with a qualifying period. Family members may be insured during the period in which the employee is covered by the collective agreement according to point 1.4.2.

1.4.4. Where it is indicated whether you are covered by an individual or collective insurance agreement

It is stated in the insurance policy if you have an individual or collective insurance agreement.

1.5. What the insurance covers

The insurance covers the costs of treatment during the insurance period as a result of illness or injury according to the terms of insurance.

An insurance case shall be deemed to have arisen at the time the insured party gets examined or initially seeks treatment for an illness or injury subject to coverage. Multiple injuries and instances of illness that are medically linked are counted as one insurance case.

For the treatment to be covered by the insurance, it must be recognised by medical experts in the Nordic countries. The treatment must be medically necessary and correct for the injury in question. If the treatment becomes more extensive or the expense is greater than what is considered necessary, the insurer may reduce the compensation to a normal level. It is the treating doctor who assesses whether it is medically necessary to start a treatment.

The insurer's period of liability is unlimited during the insurance period. If the insurance is terminated, see Chapter 14.

The insurance policy indicates the special terms related to the insurance as a supplement to the insurance elements covered by these general terms.

1.5.1. Qualifying period

Collective insurance agreements can be signed with or without a qualifying period; your insurance policy states if you have a qualifying period. If the insurance applies with a qualifying period, the insurance does not reimburse treatment for illness or injury that has been treated or known to the insured party prior to taking out the insurance. Existing illnesses can be covered by the insurance if they have been 100% free from symptoms, check ups, medication and treatment during the last 24 months before the illness or injury was reported to the company.

1.5.2. Excess

The insurance can be taken out with or without excess. The insurance policy indicates if your insurance involves excess, as well as the amount of the excess. The excess is calculated on each separate insurance case and must be paid by the insured party directly to the healthcare provider.

There is no excess for patient fees for publicly funded care.

1.5.3. Referral requirement

The policy holder may choose to take out the insurance with or without a referral requirement. It is not possible to combine a referral requirement with excess. Your insurance policy indicates what is included in the insurance.

A referral requirement means that the insurance only reimburses costs for healthcare and treatment for which the primary treating doctor has made a referral. There is no reimbursement for care or treatment costs that have arisen before a referral to a doctor within specialist care has been issued.

When the need for care arises, the insured party is to turn to a doctor within the primary care system. A doctor within primary care is to carry out a basic medical examination and/or treatment as is enjoined on him/her as the treating doctor. What is included in the basic medical examination/treatment is dependent on the illness in question and may, for example, include the taking of samples, x-ray examination, treatment or other examination. If, after the primary basic examination, it is shown that the responsibility for healthcare is to be transferred to specialist care, the treating doctor within primary care then issues a referral to a doctor within specialist care.

Once the referral has been issued, the insured party must contact Helpline who will assist with the planning and booking of care. The basic medical examination is therefore not covered by the insurance.

1.5.4. Crisis support

The insurance covers costs for up to 10 psychotherapy sessions per insurance case, for example, in the event of an accident, death, serious illness, assault or break in. This treatment requires no referral but must be pre-approved by the insurer. No excess applies to crisis support. The event that triggered the acute mental crisis should be close in time to the insurance case and be directly linked to the crisis symptoms. Crisis support does not include common treatment by a psychologist for symptoms that have developed as a result of mental stress over an extended period of time and which do not require direct assistance from a psychologist.

1.5.5. Second Opinion

Additional medical assessment by a medical specialist. The right to a second opinion refers to one consultation per insurance case, and only applies to: Life-threatening illness and/or injury Particularly risky treatment The consultation shall be pre-approved by the insurer.

1.5.6. Travel expenses

The insurance reimburses expenses for necessary and reasonable travel expenses in connection with hospitalisation/surgery/cancer treatment and/or rehabilitation (does not apply to treatment by a physiotherapist/naprapath/chiropractor or psychologist).

Travel expenses for specialist appointments are reimbursed if the insured party has more than 150 km between the home and the treatment facility, one way. If you use your own car, the insurance covers mileage allowance in accordance with the Swedish Tax Agency rules for such.

The insurance also reimburses expenses for necessary and reasonable travel and subsistence costs for an adult companion in connection with hospitalisation and surgery when the insured party is under the age of 18 and/or when medically necessary. It is the treating doctor who decides what is medically necessary.

All journeys must be pre-approved by the insurer.

1.5.7. Food and accommodation

The insurance covers necessary and reasonable costs of subsistence (food and accommodation) in connection with hospitalisation and surgery (does not apply to parts involving a specialist, physical therapy or psychotherapy). The insurance also reimburses expenses for necessary and reasonable travel and subsistence costs for an adult companion in connection with hospitalisation and surgery when the insured party is under the age of 18 and/or when medically necessary. If a companion is required for an insured party over the age of 18, a medical certificate is required.

Subsistence costs are reimbursed according to the Swedish Tax Agency's rules on food and accommodation, and must be pre-approved by the insurer.

1.6. Where the insurance is valid

The insurance is valid for treatment in the Nordic countries at healthcare providers/hospitals/clinics with which the insurer has a cooperation agreement. This means that all treatment shall commence in the Nordic countries and that the insured party shall be referred by a medical specialist in the Nordic countries.

The insurance applies to treatment in the Nordic countries even if injury or illness occurs outside the Nordic region.

If the insurer does not locate a healthcare provider and/or expertise in the Nordic region, the insurer can use a healthcare provider in the European network, as close to the Nordic region as possible.

1.7. Registration and forwarding of health-related information/medical documentation

Health-related information/medical documentation received by the insurer can be registered by the insurer and forwarded to a selected treatment institution.

1.8. Insurance period and renewal

If the insurance agreement or the group agreement is not terminated by one of the parties, the insurance agreement is renewed for one year at a time as long as the premium is paid. The insurer retains the right to refuse renewal of an insurance when special grounds entail that it is reasonable to terminate the insurance arrangement.

1.9. The insurer's right to change the terms of insurance and premiums

The insurer can amend terms of insurance and premiums each year in conjunction with the annual renewal.

The insurer has the right to use index regulation of the premium tables. Index regulation is carried out each year on the principal maturity date of the insurance and using the consumer price index (CPI) as per 15 October of the previous year as a comparative figure. The insurer also has the right to change the premium on the principal maturity date of the insurance due to changes in the relationship between costs of injury and premium. Individual agreements are also priced on the basis of an age-based premium table.

The insurer also has the right, during the insurance period, to change these terms of insurance and the insurance agreement in general if required due to the nature of the insurance agreement or any other special circumstance. Other special circumstances include changes in legislation or legal enforcement, government regulation or other essential prerequisites for the insurance agreement.

In order for a term amendment to take effect with regard to policy holders and insured parties, the person concerned is required to receive written information that they may need to know about the change. The amendment will then apply as of the next premium payment. Insignificant changes and amendments due to a change in legislation, change in legal enforcement or government regulation may take effect immediately.

The insurer reserves the right to transfer the agreement to another insurer in accordance with the provisions of the Swedish Insurance Act through portfolio assignment.

1.10. The policy holder's right to terminate and amend the insurance agreement

The policy holder has the right to change the insurance agreement within the framework of the terms of the insurance policy and according to what the insurer allows. The insurer can stipulate that the amendment is conditional on the policy holder accepting that terms of insurance and prices after the date of amendment apply to the entire agreement.

In the case of individual insurance agreements, the policy holder may terminate the insurance at any time until the end of the insurance period.

In the case of collective insurance agreements, the insured party can give notice of termination of the insurance at any time. If no termination period is specified, the insurance expires at the end of the current month. If the notice of termination comes from the group representative, the insurance expires for all insured parties as of the termination date specified in the notice, but not earlier than one month from the notice of termination.

2. Who has the right to sign a binding agreement for the insurer?

Binding agreement orders are made in writing from the insurer's head office. Financial advisers, insurance advisers, sellers or intermediaries, or similar, have no power of attorney to sign a binding agreement for the insurer.

3. Entry into force

3.1. When the insurer's liability enters into effect for an individual insurance agreement

Individual insurance agreements cover individuals and are signed on an individual basis.

Provided that the insured party has submitted an approved health declaration and the insurance can otherwise be granted on normal terms, the insurance applies from the day after the premium is paid. (Date of entry into force)

3.2. When the insurer's liability enters into effect for a collective insurance agreement

The collective insurance agreement is valid from the date on which the insurer receives written notice that the agreement is accepted by the policy holder and the first premium has been paid.

For the individual member, the insurer's liability enters into effect when he or she satisfies the requirements for the application procedure according to the insurance agreement, and is also of full earning capacity and the insurer has received notice of this.

For registration of an insured party after the collective insurance agreement has been entered into, any new group member is to contact the insurer.

3.2.1. When the insured party is to submit a health declaration to the insurer, the following applies:

For members of a group covered by a collective insurance agreement, the insurer's liability enters into effect when the group member has fulfilled the terms of insurance stipulated in the insurance agreement and provided that the insured party submits a health declaration that can be approved by the insurer.

3.2.2. When the insured party shall not submit a health declaration to the insurer, the following applies:

For members of a group covered by a collective insurance agreement, the insurer's liability enters into effect when the group member has fulfilled the terms of insurance stipulated in the insurance agreement and provided that the insurer has given written confirmation that the person involved satisfies the application requirements indicated in the insurance agreement.

4. The disclosure obligation when concluding the insurance agreement and the consequences of providing incorrect information

4.1. The policy holder's and the insured party's obligation to provide information about the risk

The policy holder and the insured party shall provide correct and complete answers to the questions of the insurer and are required to provide information at the insurer's request, which may be relevant to the question of whether the insurance is to be granted, extended or renewed.

4.2. Consequences of providing incorrect information

If the insured party has deceitfully or in bad faith provided incorrect or incomplete information, the insurance is invalid and the insurer is free from liability for insurance cases that occur thereafter.

If the insured party has intentionally or through gross negligence provided incorrect or incomplete information relevant to the risk assessment, and the insurer would not have granted the insurance if the disclosure obligation had been fulfilled, the insurer is free from liability for insurance cases that occur and may give notice of termination or amendment of the insurance.

If the insurance becomes invalid due to fraudulence, the insurer retains any premium paid. If the insurance is terminated, the remaining premium is refunded to the policy holder. Any compensation paid out shall be paid back to the insurer. The insurer can offset counterclaims.

5. Exceptions and limitations

The insurer does not cover costs for:

1. Treatment of illness/injury requiring emergency assistance/treatment

2. Treatment that is not medically necessary, treatment carried out by non-qualified medical professionals and/or which is not based on scientifically controlled clinical studies, as well as complications and other aftereffects of such treatment.

3. Costs associated with cosmetic treatment/surgery and complications and the aftereffects of such treatment.

4. Treatment of obesity, such as diet, weight regulation and obesity surgery, as well as aftereffects of such treatment/surgery.

5. injury sustained through a nuclear explosion or radioactive radiation.

6. Removal and examination of skin changes/moles/birthmarks without suspicion of malignancy.

7. Scheduled consultation, treatment, surgery and travel expenses where the insured party does not appear or cancels the appointment later than 24 hours beforehand.

8. Dialysis treatment.

9. Treatment or surgery relating to sterilisation, abortion, prevention, pregnancy, birth, family planning/infertility or gender reassignment and the aftereffects of such treatment.

10. Treatment of diseases covered by the Communicable Diseases Act.

11. Investigation, treatment and/or surgery relating to sleep disorders, snoring and sleep apnea, as well as associated medical equipment.

12. Consultation, treatment, check up or surgery relating to teeth, dental disease and dental injuries performed by a dentist, dental specialist, dental hygienist and dental technician.

13. Treatment of drug, gambling and medication addiction along with sickness, injury or accidents caused by alcohol, other intoxicants, medicines or narcotics.

14. Treatment or surgery as a result of injury/pain/illness that the insured party caused themselves through gross negligence or risky behaviour.

15. Treatment by a psychiatrist and/or at a psychiatric institution, or an institution for treatment of personality disorders.

16. Treatment of psychosis or other serious mental illnesses.

17. Purchase, rental and testing of medical devices such as hearing aids, crutches and orthopaedic insoles.

18. Purchase of medication.

19. Eye test, glasses and contact lenses as well as corrective surgery for near- and far-sightedness and astigmatism.

20. Vaccination, preventative health check and certificates, unless otherwise agreed.

21. Stays at a rehabilitation institution without active rehabilitation, including stays at a spa, baths and other such institution.

22. investigation and treatment of dementia.

23. The insurer does not reimburse costs or expenses that can otherwise be compensated through laws, regulations, conventions, other insurance or collective agreement.

6. Responsibility of the treating institutions for the treatment

The insurer has entered into agreements with hospitals that offer treatment to persons insured with the insurer. These hospitals have insurance policies that cover the consequences of any errors or mistakes that occur during treatment. Non-hospital specialists who treat someone insured by the insurer shall have such liability insurance. The financial consequences of errors or mistakes in conjunction with treatment are the responsibility of the treating institutions, not the insurer. Nor is the insurer responsible for injury or other damage of a non-financial nature.

7. Premium for smokers

For individual insurance, the premium is calculated based on whether the insured party smokes. If the insured party starts smoking daily and the premium is calculated on the basis that the insured party does not smoke daily, he/she is obligated to promptly inform the insurer of this. If this information is not provided by the first premium payment at the latest, the insurer's liability for each future insurance case will be reduced in relation to the omission.

If the premium is calculated based on the fact that the insured party smokes, and the insured party has subsequently been smoke-free for at least one calendar year, the insured party may notify the insurer in writing, in which case the premium supplement for smoking can be removed following a review.

8. Premium payment

The premium is fixed for one insurance year at a time and is calculated, inter alia, on the basis of the composition of the group, the age of the insured party, the scope of the insurance, the injury trend in the group and the current premium tables of the insurer.

The premium is calculated from the first of the month after the insurance has been granted.

8.1. Notification of premium payments and consequences of non-payment

An insured party or payer receives notification regarding payment of the premium. The deadline for payment of the premium, aside from the initial payment, is one month from the date that the insurer issues the premium notification.

If the premium is not paid by the deadline, the insurer will send a reminder with a payment deadline of at least 14 days. A statutory reminder fee is charged for each reminder. If payment of the premium, aside from the initial payment, is not made by the date specified in the reminder, the insurer's liability ceases to apply. The insurer may give notice of termination of the insurance fourteen days from such notice, if the premium has not been paid during this time. The notification of termination and the date when the policy expires are to be sent to the group representative and the other members.

9. Disclosure requirement for payment claims and consequences of incorrect information

9.1. Disclosure obligation and documentation

Any person who considers to have a claim to direct to the insurer shall disclose this information without undue delay and provide the insurer with the particulars and documents that he or she has available and which the insurer needs in order to consider the claim and pay the compensation.

The insurance payout may be dependent on the claimant providing the insurer with the authorisations necessary to obtain information so as to be able to consider the claim for compensation. The insurer may require an examination to be done by a specific doctor. Both parties are entitled to obtain an assessment from a specialist.

9.2. Consequences of providing incorrect information

If an insured party has intentionally or through gross negligence been inaccurately stated, kept secret or concealed something that is relevant to the assessment of the right to compensation from the insurance, the compensation that would otherwise be paid out may be reduced to a reasonable amount given the circumstances.

10. Deadlines

10.1. Deadline for reporting injury

Insurance cases shall be reported to the insurer without delay and at the latest within one year of the policy holder/insured party having become aware of the circumstance on which the claim is based, otherwise the right to compensation may be reduced based on what is reasonable given the circumstances.

10.2. Deadline for bringing an action against the insurer

Any person wishing to claim insurance compensation must bring an action against the insurer within ten years from the date on which the circumstance that entitles the person to such coverage under the insurance agreement has occurred, otherwise the right to compensation will be lost. If a claim has been made to the insurer within that period, the time limit is always at least six months from when the insurer has declared that a final decision on the claim.

10.3. Interest provisions during payout

If the insurer has not compensated a justified and documented claim within one month of receipt, the insurer shall pay default interest in accordance with the Interest Act (1975:635).

10.4. Treatment guarantee offer regarding treatment within a maximum of 14 working days

The insurance guarantees access to treatment within 14 working days from the date the insurer receives complete and necessary medical documentation. The treatment shall be compensable and is pre-approved by the insurer. If a treatment consists of several planned treatments, the treatment guarantee applies to the first treatment.

The treatment guarantee does not apply if the insured party cannot be treated or if the treatment has to be postponed for medical reasons. During the period of the treatment guarantee, the insured party is obligated to keep the insurer informed of the best way to contact them.

If the insured party does not accept the offer of treatment, is absent from scheduled treatment, wishes to receive treatment after the expiry of the treatment guarantee, or if the insured party comes to an agreement with the doctor/healthcare provider to postpone the treatment, the treatment guarantee shall cease to apply.

If the treatment guarantee is not met, the insured person is entitled to compensation of SEK 500 per day starting from Day 15 until the offer of treatment can be fulfilled, but for no longer than 30 days.

11. Compensation rules/payment of expenses

Expenses that are pre-approved by the insurer and covered by the insurance are reimbursed after submission of dated and specified original receipts, in addition to a compensation claim containing the following:

- cause/diagnosis
- date of treatment
- onset of symptoms
- treatment facility/doctor’s name and address
- the treatment recipient’s (insured party’s) name, address, national registration number and account number

Costs for hospitalisation with and without surgery and rehabilitation that are pre-approved by the insurer are paid directly to the hospital/rehabilitation institution.

Travel and subsistence costs are reimbursed after submission of specified original receipts.

If the treatment guarantee is not fulfilled, the compensation is paid to the insured party.

12. Recourse

If the insured party can claim compensation for the injury from a third party, the insurer is admitted in the policy holder’s right in respect of the third party in the case of payment and compensation. The person/policy holder to whom the injury relates is required to provide the insurer with all the information available to them that is relevant to the insurer’s implementation of the recourse.

If the policy holder does not fulfil their obligations in relation to the agreement that has been concluded and the insurer is liable to pay compensation for that reason, the insurer may pursue recourse against the policy holder.

13. Treatment of disputes

If a dispute arises between a policy holder/insured party and insurer, it can be dealt with in a general court in Sweden in accordance with Swedish law.

Litigation shall be settled in accordance with Swedish law.

14. Termination of the insurance

14.1. Individual insurance is no longer valid:

- when the insured party is no longer permanently residing in the Nordic countries, unless otherwise specifically agreed
- from the time the insured party is no longer affiliated with a social insurance office in the Nordic countries

- from the time the insurance agreement ceases to apply due to termination by the policy holder
- from the time that notice of termination of the insurance agreement is given until the end of a premium period, but no earlier than one month after such notice has been sent to the policy holder.
- In the event of non-payment of premium

The right to reimbursement of costs relating to treatment ceases when the insurance policy is no longer valid.

14.2. For collective insurance agreements, the insurance ceases to be valid:

- when the insured party is no longer a member of the group. The insurance ceases to be valid three months from the date when the insured party leaves the group
- when the insured party turns 72 years of age, if no other agreement has been established or indicated in the insurance policy
- when the insured party is no longer permanently residing in the Nordic countries, unless otherwise specifically agreed
- from the time the insured party is no longer affiliated with a social insurance office in the Nordic countries
- from the time the insurance agreement ceases to apply due to termination by the policy holder
- from the time that notice of termination of the insurance agreement is given until the end of a premium period, but no earlier than one month after such notice has been sent to the policy holder and relevant group members.

14.3. Insured party's right to continued insurance in the case of collective insurance

Continued insurance is the individual group member's right to continued insurance if the group insurance agreement is cancelled through notice of termination by the insurer or if the individual group member no longer belongs to the group defined in the agreement.

If the insured party has been covered by the insurance for at least six months, they shall be entitled to continued insurance without submitting a new health declaration:

- if the insured party voluntarily terminates their employment
- if the insurance is terminated by the employer (the policy holder)
- If the insurer terminates the collective insurance agreement at the end of the contract period

Continued insurance must be taken out within 3 months from the date of the old insurance having been declared discontinued, without interruption by premium payment. With continued insurance, corresponding insurance is offered with individual terms and premiums.

14.4. Insured party's right to follow-up cover in the case of collective insurance

If a collective insurance ceases to be valid on the grounds that the insured party is leaving the group for a reason other than that of an age limit being reached, the insured party and their co-insured parties are entitled to three months ' extended insurance coverage (follow-up cover) after leaving. The follow-up cover can be used for treatment of an injury for as long as the cover applies.

Entitlement to follow-up cover does not apply in any case if the insured party:

- has been covered by the insurance for a period of less than six months when it ceases to be valid
- has received or been able to obtain comparable insurance elsewhere
- has reached a certain age and the insurance has ceased to be valid on this basis, as indicated in the terms of insurance
- has personally terminated their insurance despite membership in the group
- if the insurance has been terminated due to an unpaid premium.

15. Special provisions

15.1. War and unrest

The insurance does not apply to participation in military forces with assignments outside the Nordic countries, unless the insured party certifies that the injury cannot be related to this.

The insurance does not apply to injury/illness that shows symptoms within 1 year of the end of a period of stay in a country where war or warlike unrest prevails and which may be considered a result of the war or unrest. If there is an outbreak of war or warlike unrest while the insured party is staying in the region, the insurance applies for the first month following the outbreak, provided that the insured party does not participate in the war or the warlike unrest.

15.2. Force majeure

The insured party cannot make a claim under these terms and conditions if the insurer is prevented from fulfilling its obligations due to force majeure. The insurer shall not be liable for any loss that may arise from delays in the processing time, investigation or disbursement due to war, political unrest, legal decrees, government action or industrial action in the workplace.

Specific terms no. 06.01.01

Hospitalisation with surgery

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the insurance Hospitalisation with surgery.

2. What the insurance covers

Hospitalisation with surgery is an element that reimburses:

- Costs of surgery and care when admitted at a private hospital
- Rehabilitation costs

2.1. Treatment at a private hospital

The insurance covers the costs of medically necessary diagnosis, treatment and surgery of bodily illnesses requiring an overnight stay in hospital. A referral form a doctor is required and the hospitalisation/treatment shall be pre-approved by the insurance company.

The costs that are reimbursed with regard to: Hospitalisation with surgery

Costs of medical treatment, diagnosis and surgery of a bodily illness in a private hospital, requiring an overnight stay in hospital, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the private hospital by the insurer
Necessary examinations, tests and samples in direct and immediate connection with the surgery at the hospital	Is paid directly to the private hospital by the insurer
Necessary medications and aids used and administered during treatment/surgery in the hospital	Is paid directly to the private hospital by the insurer
Necessary medical devices that are an integral part of the body, e.g. prostheses and implants	Is paid directly to the private hospital by the insurer
Rehabilitation up to 28 days at a rehabilitation institution in the Nordic countries. The rehabilitation must be a necessary and direct consequence of and necessary part of the surgery, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the rehabilitation institution by the insurer

Specific terms no. 06.02.01

Day surgery. Surgery without hospitalisation

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Day surgery.

2. What the insurance covers

The element Day surgery reimburses:

- Costs for surgery at a private hospital or approved medical specialist, which does not require an overnight stay at a hospital.

2.1. Day surgery

The insurance covers the costs of necessary surgery that does not require overnight stay at a hospital. A referral form a doctor is required and the surgery shall be pre-approved by the insurer.

The costs that are reimbursed with regard to: Day surgery

Costs for surgery at a private hospital or approved medical specialist which does not require an overnight stay, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts
Necessary examinations, tests and samples in direct and immediate connection with the surgery	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts
Necessary medications and aids used and administered during the surgery	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts
Necessary medical devices that are an integral part of the body, e.g. prostheses and implants	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts

Specific terms no. 06.03.01

Hospitalisation without surgery

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Hospitalisation without surgery.

2. What the insurance covers

Hospitalisation without surgery is an element that reimburses:

- costs of treatment when admitted to a private hospital (no surgery)
- rehabilitation costs

2.1. Treatment at a private hospital

The insurance covers the costs of necessary treatment of bodily illnesses requiring an overnight stay in hospital (no surgery), after referral from a doctor. The hospitalisation/treatment must be pre-approved by the insurer

The costs that are reimbursed with regard to: Hospitalisation without surgery

Costs of medical treatment (not surgery) of a bodily illness in a private hospital, requiring an overnight stay in hospital, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the private hospital by the insurer
Necessary examinations, tests and samples in direct and immediate connection with the treatment	Is paid directly to the private hospital by the insurer
Necessary medications and aids used and administered during the treatment	Is paid directly to the private hospital by the insurer
Necessary medical devices that are an integral part of the body, e.g. prostheses and implants	Is paid directly to the private hospital by the insurer
Rehabilitation up to 28 days at a rehabilitation institution in the Nordic countries. The rehabilitation must be a necessary and direct consequence of and necessary part of the treatment, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the rehabilitation institution by the insurer

Specific terms no. 06.04.01

Specialist medical treatment

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Specialist medical treatment.

2. What the insurance covers

The element Specialist medical treatment is an element that subsequently reimburses the documented costs of medically necessary treatment for a bodily illness of the insured party which does not involve hospitalisation and overnight stay. The treatment must be carried out by a licensed medical specialist. Must be pre-approved by the insurer. May require a referral if indicated in the insurance policy.

The costs that are reimbursed with regard to: Specialist medical treatment

Costs for treatment of a bodily illness by a medical specialist. Must be pre-approved by the insurer	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts
Necessary examinations, tests and samples in direct and immediate connection with the treatment	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts
Necessary medications and aids used and administered during the specialist medical treatment	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts

Specific terms no. 06.05.01

Cancer treatment

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Cancer treatment.

2. What the insurance covers

The element Cancer treatment is an element that reimburses:

- costs for the diagnosis and primary treatment of cancer diseases in hospitals, such as surgery, chemotherapy and radiotherapy
- rehabilitation costs

2.1. Cancer treatment

The insurance reimburses the costs of medically necessary examination, surgery and treatment of cancer, after referral from a doctor. The hospitalisation/treatment must be pre-approved by the insurer.

The costs that are reimbursed with regard to: Cancer treatment

Costs for the diagnosis and primary treatment of cancer diseases in hospitals, such as surgery, chemotherapy and radiotherapy, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the private hospital by the insurer
Necessary examinations, tests and samples in direct and immediate connection with the cancer treatment	Is paid directly to the private hospital by the insurer
Necessary medications and aids used and administered during the treatment at the hospital/clinic	Is paid directly to the private hospital by the insurer
Necessary medical devices that are an integral part of the body, e.g. prostheses and implants	Is paid directly to the private hospital by the insurer
Rehabilitation up to 28 days at a rehabilitation institution in the Nordic countries. The rehabilitation must be a necessary and direct consequence of and necessary part of the cancer treatment, after referral from a doctor. Must be pre-approved by the insurer	Is paid directly to the rehabilitation institution by the insurer

Specific terms no. 06.06.01

Physical therapy. Physiotherapist, chiropractor and/or naprapath

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Physical therapy.

2. What the insurance covers

Physical therapy is an element that subsequently reimburses documented costs of medically necessary physiotherapy, chiropractor and/or naprapath treatment of the insured party by a licensed healthcare provider, after referral from a doctor. Must be pre-approved by the insurer.

The costs that are reimbursed with regard to: Physical therapy

Physical therapy by a licensed physiotherapist, chiropractor and/or naprapath after referral from a doctor. Up to 24 treatments per calendar year. The treatment must be pre-approved by the insurer	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts

Specific terms no. 06.09.01

Psychotherapy

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Psychotherapy.

2. What the insurance covers

The element Psychotherapy is an element that subsequently reimburses documented costs of medically necessary treatment of the insured party by a licensed psychologist/psychotherapist stage II, of mild mental disorders. Must be pre-approved by the insurer.

Other costs, such as doctor's visits, other specialist care, hospital care, travel or drugs for mental illness/disorders are not reimbursed.

Unless otherwise agreed, the number of consultations is limited to 10 per insurance case.

The costs that are reimbursed with regard to: Psychotherapy

Costs for treatment of mild mental disorders. Must be pre-approved by the insurer. Maximum 10 consultations per insurance case	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts

Specific terms no. 06.11.01

Psychotherapy Top

1. The terms that apply

The general terms and conditions in DKV Hälsa's Healthcare Insurance apply in conjunction with these special terms for the insurance Psychotherapy Top.

2. What the insurance covers

The insurance Psychotherapy Top is a healthcare insurance that reimburses documented expenses for psychosocial counselling and psychologically necessary treatment of an insured party by a cross-professional team consisting of social workers, licensed nurses, licensed psychologists and licensed psychotherapists II, for mild mental
disorders.

The insurance Psychotherapy Top covers:

- Domestic problems (family, relationship), maximum 5 counselling sessions (phone or online) and 10 consultations per insurance case
- Family and job satisfaction problems, maximum 5 counselling sessions per insurance case
- Legal consultation, maximum 1 telephone call or agreement per insurance case
- Financial consultation, maximum 1 telephone call or agreement per insurance case

The insurance Psychotherapy Top can be used around the clock for counselling and consultation in connection with current psychosocial problems. Treatment always starts via the insurer's online service or telephone. Objective evaluation and guidance via phone or online service is the basis for starting
treatment.

No referral is required from a doctor and the treatment does not need to be pre-approved by the insurer.

Other costs, such as medical treatment, other specialist care, hospital care, travel or drugs for mental illness/disorders are not reimbursed.

The costs that are reimbursed with regard to: Psychotherapy Top

Costs for treatment of mild mental disorders. Treatment always starts via the insurer's online service or telephone. • Domestic problems (family, relationship), maximum 5 counselling sessions and 10 consultations per insurance case • Family and job satisfaction problems, maximum 5 counselling sessions per insurance case • Legal consultation, maximum 1 telephone counselling session per insurance case • Financial consultation, maximum 1 telephone counselling session per insurance case	Is paid directly to the healthcare provider by the insurer.

Specific terms no. 06.12.01

Supplementary insurance

1. The terms that apply

DKV Hälsa's general terms and conditions apply in conjunction with these specific terms for the element Supplementary insurance. The text of these specific terms takes precedence over the general terms and conditions.

2. What the insurance covers

The element Supplementary insurance is an element that reimburses:

- Drugs
- Speech therapist
- Dietician
- Eye examination
- Home assistance
- Aids
- Vaccination

2.1. Supplementary insurance

The insurance reimburses the costs of medically necessary examination and treatment, after referral from a doctor. All treatment must be pre-approved by the insurer.

The costs that are reimbursed with regard to: Supplementary insurance

Drugs	The insurance reimburses necessary costs for prescription drugs that are covered by the drugs allowance. DKV reimburses costs up to the limit corresponding to the high-cost protection threshold over a 12-month period.	Is paid directly to a pharmacy and reimbursed afterwards following submission of original receipts.
Speech therapist	After referral from a doctor, the insurance reimburses necessary costs for a maximum of ten consultations per injury occurrence with a licensed speech therapist.	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts.
Dietician	After referral from a doctor, the insurance reimburses necessary costs for a maximum ten consultations per injury occurrence with a licensed dietician.	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts.
Eye examination	The insurance reimburses one eye examination per insurance year by a licensed optician. The insured party must personally book and pay for the eye examination. DKV reimburses the cost when the insurance claim and receipt are received. Travel costs in connection with an eye examination are not covered.	Is paid directly to a optician and reimbursed afterwards following submission of original receipts.
Reimbursement for home assistance	The insurance provides the right to 10 hours of necessary home assistance for a period of 14 days after surgery that can be reimbursed by the insurance. A precondition is that the home assistance can be provided by an established company located in the insured party's area of residence.	Is paid directly to the home assistance service and reimbursed afterwards following submission of original receipts.
Aids	The insurance reimburses necessary and reasonable costs for aids deemed necessary for the healing process of an illness or injury, with a maximum of one half (0.5) price base amount per injury occurrence. The aid is to be prescribed by a treating doctor. The insurer does not cover costs for testing and purchase of hearing aids, glasses and contact lenses or dental treatment of any kind.	Is paid directly to the healthcare provider by the insurer or reimbursed afterwards following submission of original receipts.
Vaccination	The insurance covers vaccinations against seasonal influenza, TBE vaccination and vaccination for trips abroad. The insured party must personally book and pay for the vaccination. DKV reimburses the cost when the insurance claim and receipt are received. Travel costs in connection with vaccination are not covered.	Is paid directly to the healthcare provider and reimbursed afterwards following submission of original receipts.

Processing of personal data

We care about your privacy and integrity. For information on how we process personal data see our privacy policy at www.dkvhalsa.se.

Examination of decisions in insurance matters

Complaints to the company

If you have any questions or complaints about the insurance, these can be directed to DKV Hälsa by phone, e-mail or regular mail.

If you have a complaint and you deem it to be a serious complaint, we recommend that you submit this by mail to our Complaints Manager:

DKV Hälsa
S- 105 39 Stockholm

Tel. 08-619 62 00
Fax: 08-619 62 80.
E-mail: klagomal@dkvhalsa.se

Important!
For faster processing of your complaint, enter the name and address of the policy holder and the contract number of the insurance policy.

Complaints about the healthcare

First, contact your healthcare provider, and if you are not satisfied with their actions you can turn to:
Inspektionen för Vård och Omsorg (Health and Social Care Inspectorate)
Box 45184, 104 30 Stockholm.
Telephone: 010-788 50 00.
www.ivo.se

Next review body

If you are dissatisfied with DKV Hälsa's complaint handling or the outcome of this, the matter can be forwarded to:

Allmänna reklamationsnämnden (National Board for Consumer Disputes)
Box 174, 101 23 Stockholm
Telephone 08-508 860 00
www.arn.se

For free advice on insurance matters:
Konsumenternas Försäkringsbyrå (Swedish Consumers' Insurance Bureau)
Box 24215, 104 51 Stockholm
Telephone: 0200-22 58 00
www.konsumenternas.se

Insurance cases can also be examined by the Swedish courts, primarily at the District Court. Legal representation costs are not covered by the insurance.

Definitions

The definitions below determine what each word means in the insurance agreement

Emergency assistance
Assistance given in the event of unforeseen acute illness/injury or acute deterioration of a known illness that requires immediate treatment.

Treatment
Examination and/or therapeutic measures carried out by a licensed healthcare professional or other staff member who is publicly authorised in the country where they practice. In order for the treatment to be covered by the insurance, it must be generally accepted by medical experts in the Nordic countries. Treatment must be necessary, rational and adequate for the illness in question. Risk and costs must be in proportion to the benefit.

Treatment facility
The institution or clinic where examination or treatment by a specialist or care institution is carried out and normally takes place.

Cancer
Malignant disease that emerges uninhibited through uncontrollable cell growth and the development of growths that are not encapsulated and which can develop metastases. Leukaemia and malignant lymphomas are also cancer. The diagnosis shall be made by a medical specialist at a public or private hospital approved by the insurer, through microscopic examination of body tissue or fluid.

Day surgery
Operation that does not require overnight stay

FAL - Swedish Insurance Contracts Act
The Insurance Contracts Act (2005:104) governs the principal rights and obligations in the relationship between the insurer and the policy holder, the insured party or their right holder.

Of full earning capacity
"Of full earning capacity" means that the person in question can perform their regular work within the scope of a full-time position. Those who have fully or partially diminished work capacity, or who receive compensation from a social insurance body as a result of fully or partially diminished work capacity, are under no circumstances considered to be of full earning capacity.

Physical therapy
Physiotherapist, chiropractor and/or naprapath treatment. Treatment based on accepted treatment methods by a physiotherapist, chiropractor or naprapath who is licensed in the country where the treatment is performed.

Physiotherapist
Since 1 January 2014 in Sweden, the professional title physiotherapist (*fysioterapeut*) is used instead of *sjukgymnast*.

Insured party
Insured party is the person who health is covered by the insurance.

Insurance case
An insurance case shall be deemed to have arisen at the time the insured party gets examined or seeks treatment for an illness or injury subject to coverage. Multiple injuries and instances of illness that are medically linked are counted as one insurance case. This does not apply if the insured party has not had symptoms or received treatment or medication for more than 12 consecutive months since the last examination or treatment session. A new insurance case is then deemed to have arisen when the insured party has an examination or treatment session following such a period.

Insurer
Storebrand Helseforsikring AS
www.storebrand.no/helse - www.dkvhalsa.se

Policy holder
The policy holder is the one who concludes an insurance agreement with the insurer. The policy holder has ownership and right of disposal over the insurance.

Insurance period
The insurance period is the time that the insurance is in effect. The insurance is renewed once a year. For the individual insured party, as part of a group insurance, the insurance period is understood as the period during which the person in question belongs to the group covered by the insurance agreement.

Individual insurance agreement
Insurance that covers individuals and which is taken out on an individual basis. The insurance is subject to the provisions relating to individual insurance in the Insurance Contracts Act (2005:104).

Hospitalisation
Treatment and/or examination at a private hospital, when the treatment or examination requires the patient to remain in hospital for at least one night for medical reasons.

Collective insurance agreement
Insurance that covers individuals in a defined group. The insurance is subject to the provisions relating to group insurance in the Insurance Contracts Act (2005:104).

Cosmetic treatment
Treatment that is not medically necessary and which is carried out with the aim of changing the patient's appearance to something that they perceive to be an improvement.

Bodily illness
Disruption of normal physiological states and processes in one or more organs that produces or will produce, bodily discomfort, and which leads to a more than negligible impairment and/or diminished physical ability, which is perceived by the sick individual and their doctor as requiring treatment.

Laser treatment
Treatment with a medical laser instrument in place of a surgical procedure.

Doctor
Medically trained person, publicly authorised (licensed) to treat patients by the authorities of the country where the person in question practices.

Mild mental disorder
Mild mental disorder encompasses anxiety disorders, mild depression, phobias, obsessive-compulsive disorder and psychological reactions to serious life events.

Members
Members are the insured individuals included in a collective insurance agreement and who meet the application requirements specified in the insurance agreement.

Nordic countries/Nordic region
The Nordic countries/Nordic region in this insurance includes Norway (Excluding Svalbard), Sweden, Finland and Denmark (excluding Greenland and the Faroe Islands).

Accidental injury
Accidental injury is a bodily injury to which the insured party has involuntarily sustained through a sudden external event.

Surgery
Surgical procedure that involves cutting through the skin or mucous membrane to treat (take therapeutic action) or remove a diseased organ or body part. Does not apply to examination. In order for the surgery to be covered by the insurance, it must be generally accepted by medical experts in the Nordic countries. The surgery must be necessary, rational, adequate, suitable and sufficient for the illness in question. Risk and costs must be in proportion to the benefit. The surgery must be carried out at a hospital, clinic or other institution where such procedures are normally performed, and by a doctor licensed to perform the treatment. Surgery may also include laser treatment.

Patient
Person being examined and/or treated for a medical complaint by a licensed healthcare professional.

Outpatient treatment
Medical examination and/or treatment by a specialist which does not require an overnight stay in hospital.

Private patient
A patient who, on their own or through an insurance company, personally covers the costs of a treatment/examination in a hospital or by a specialist.

Private hospital
A hospital that treats private patients.

Samples
Examination of bodily fluids, tissues or organs carried out by qualified staff to identify possible medical conditions, and which is ordered by a doctor.

Mental illness
Disruption of normal mental state and processes that is perceived as requiring treatment.

Commenced treatment
Treatment initiated after referral or prescription by a doctor.

Rehabilitation
Treatment/measures to restore physical or mental functions. Treatment must be carried out by a healthcare professional who is licensed in the country where the treatment is performed.

Referral
A referral is a prescription written by a healthcare provider with prescription rights. The referral must document the necessary medical indication for initiation of treatment.

Hospital
An institution with public authorisation as a hospital, for treatment of physically ill and injured individuals.

Excess
The part of the cost of an injury that the insured party must personally cover under the terms, and which thereby reduces the insurance compensation.

Medical specialist
Public licensed and authorised medical specialist.

Severe mental disorder
Psychosis or other serious mental illness such as schizophrenia and other acute and chronic psychoses and developmental disorders.

Symptoms
Subjective or objective signs of bodily states associated with illness.

Ailment
Conditions that cause abnormal discomfort and/or pain and which involve impaired functional ability.

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