DSS HÄLSA

Cancer Care

Appendix 1:
Personalised medicine and cancer treatment

Index

8 Examination and treatment abroad – Cancer Care

Cover under this Appendix 1 applies during the Appendix 1 insurance period.

Definition of certain terms used in the insurance/policy conditions:

The Appendix 1 insurance period
The Appendix 1 insurance period is the period from when cover offered under this Appendix 1 comes into force until it ends, for whatever reason. It starts on the Cancer Care start date that is shown in your policy contract.

Further
The company supporting the claims handling services and the arrangement of treatment.

Indemnity Period
Period of thirty-six (36) months that commences from the date of the first trip that is arranged and paid for by the cover offered by this Appendix 1 in a valid claim. The indemnity period is the length of time for which the benefits offered under this Appendix 1 are payable for all claims accepted under this Appendix 1.

Sum Insured
The insurance sum applying to all cover in respect of cancer treatment abroad as referred to in Section 5, Cancer – Examination and treatment abroad ("Cancer Care") is 11,000,000 SEK per insured. This sum insured limit considers all the costs incurred by providing the cover detailed in sections 8.5.1, 8.5.2, 8.5.3 and 8.5.4.

Medical definitions

Gene Therapy Products: these contain genes that lead to a therapeutic, prophylactic or diagnostic effect. They work by inserting 'recombinant' genes into the body, usually to treat a variety of diseases, including genetic disorders, cancer or long-term diseases. A recombinant gene is a stretch of DNA or RNA that is created in the laboratory, bringing together DNA or RNA from different sources.

Somatic-Cell Therapy Products: These contain cells or tissues that have been manipulated to change their biological characteristics or contain cells or tissues not intended to be used for the same essential functions in the body. They can be used to cure, diagnose or prevent diseases.

Tissue-Engineered Products: These contain cells or tissues that have been modified so they can be used to repair, regenerate or replace human tissue.

Alternative Medicine: Medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine or the standard treatments, including but not limited to: acupuncture, aromatherapy, chiropractic medicine, homoeopathic medicine, naturopathic medicine, ayurveda, traditional Chinese medicine and osteopathic medicine.

CAR T-Cell Therapy (Chimeric Antigen Receptor T-Cell Therapy): Type of treatment in which a patient's T cells (a type of immune system cell) are changed in the laboratory so they will attack cancer cells. T cells are taken from a patient's blood. Then the gene for a special receptor that binds to a certain protein on the patient's cancer cells is added in the laboratory. The special receptor is called a chimeric antigen receptor (CAR). Large numbers of the CAR T cells are grown in the laboratory and given to the patient by infusion.

CAR T-cell Approved Protocol: The delivery of CAR T-cell therapy including a single infusion of the medication and the pre-treatment and pre-medication stages prior to the infusion, as well as the monitoring phase post-infusion, adhering strictly to the guidelines stated in the pharmaceutical licence issued by the relevant medical authorities in the country where the protocol is being delivered.

Cognitive Disorders: Disorders that significantly impair an individual's cognitive function to the point where normal functioning in society is impossible without treatment, as defined by the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

Experimental Treatment: A treatment, procedure, course of treatment, equipment, medicine or pharmaceutical product, intended for medical or surgical use, which has not been universally accepted as safe, effective and appropriate for the treatment of diseases, or injuries by the various scientific organisations recognised by the international medical community, or which is undergoing study, research, testing or is at any stage of clinical experimentation.

Follow-Up Care: Any diagnostic investigation and/or monitoring/surveillance service (by a doctor with special expertise referring to the treated disease) post treatment abroad used to identify whether the insured is suffering (or likely to suffer) from a deterioration or complication of the treated disease, with the purpose of preventing relapses or recurrences of the same disease. The follow-up care plan should be elaborated by the treating doctor abroad, indicating time intervals and type of diagnostic procedures.

Disease: Any disorder of the body, system, or organ structure or function with identifiable and characteristic set of signs and symptoms, or consistent anatomic alterations. Additionally, a diagnosis has to be made by a doctor legally registered in his practice. A disease will be considered to be all the injuries and effects arising from the same diagnosis, as well as all the ailments due to the same cause or related causes. If an ailment is due to the same cause that produced a previous disease or a related cause, the disease will be considered as a continuation of the previous one and not as a separate disease.

Medically Necessary: Healthcare services or supplies which are prescribed to the insured for the purpose of treating a covered disease or arranging a covered medical procedure with the aim to improve the insured's medical condition and recognised as effective in improving health outcomes following treatment plans that are consistent in type, frequency and duration with the diagnosis according to published peer-reviewed medical literature. The healthcare services or supplies must be cost-effective compared to alternative treatments that result in similar outcomes, including no treatment and those required for reasons other than the convenience of the insured or his/her doctor. The fact that a doctor may recommend, prescribe, order or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is medically necessary under this Appendix 1.

Preliminary Medical Certificate: Written approval, issued by Further and/or the company, which includes confirmation of cover under this Appendix 1 prior to the treatment abroad being performed in the indicated hospital, for any treatment, services, supplies or prescriptions relating to a claim.

Pre-Existing Diseases: Any disease or medical condition of the insured, which was reported, diagnosed, treated or which showed related medically documented symptoms or findings (signs) within the five years prior to the cover start date of the insured under this Appendix 1.

Prosthesis: A device which replaces all or part of an organ or replaces all or part of the function of an inoperative or malfunctioning part of the body.

Exclusion Period: A period of 90 days counting from the respective cover start date of each insured under this Appendix 1.

Reconstructive Surgery: Procedures intended to rebuild a structure to correct its loss of function.

8.1 Who Appendix 1 covers

Cover under this Appendix 1 is available for any insured (including all co-insured: insured's spouse/registered partner/cohabitant/biological children and/or adopted children) under the 'BAS', 'PLUS,' or 'PREMIUM' insurance policy to which Cancer Care is added.

For any insured that is added to the cover of this insurance contract on a mandatory/ automatic basis after the ***Cancer Care start date***, cover under this Appendix 1 comes into effect on the date they are included in the contract.

For any insured that is added to the cover of this insurance contract on a voluntary basis after the ***Cancer Care start date***, cover under this Appendix 1 comes into effect on the date they are included in the contract, but certain cover exclusions will apply, as stated in section 8.6:

- pre-existing diseases will be excluded from cover
- the application of the exclusion period.

Qualifying provisions for this Appendix 1
There is no qualifying period under this Appendix 1.

8.2 What Appendix 1 covers

This Appendix 1 is designed to offer cancer treatment outside of Sweden and the country of residence if the insured has 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 cover in the country of residence, with the aim to improve the insured's medical condition when the optimal treatment may not be available in Sweden, as identified by the provision of the Precision Medicine Service.

We provide the insured with access to the Precision Medicine Service for Covered Medical Scenarios and provide the insured with insurance cover for medical treatment identified as a Covered Line of Treatment resulting from a Covered Medical Outcome.

8.2.1 The services available under this Appendix 1:

- **Medical Concierge Service:** In respect of an approved claim, the Medical Concierge Service will arrange all details relating to the medical treatment of an individual. This includes case oversight and assistance with travel and accommodation arrangements for the individual and any eligible companion.

- **Precision Medicine Service:** This service, in the case of certain cancer diagnoses recognised as Covered Medical Scenarios, involves arranging a molecular profiling analysis in order to deliver reports indicating accurate diagnoses, individualised treatment plans, assessment of treatment resistance and precise prognoses. The service can lead to the identification of a Covered Medical Outcome.

8.2.2 Precision Medicine Service

The Precision Medicine Service provides personalised support and guidance to the insured throughout their cancer journey. This includes curated access to comprehensive genomic tests using techniques such as Next Generation Sequencing (NGS), world leading expert interpretation of lab results and a precise Expert Clinical Report, covering the delivery of a personalised cancer treatment plan specific to each insured's molecular profile.

The delivery of the service will be supervised by expert clinical staff in this medical area.

8.2.2.1 Covered Medical Scenarios for Personalised Medicine

The Precision Medicine Service can be activated when the following conditions are met:

1) The insured is actively receiving cancer treatment or has received a written recommendation for immediate cancer treatment; and

2) The cancer diagnosis is classified as Stage I, II, III or IV; and

3) For **Somatic testing** (see section 8.2.2.2 "Covered Tests" next) appropriate testing material is available in the form of a biopsy sample with a sufficient number of tumour cells. Where the sample does not contain a sufficient number of tumour cells, a liquid biopsy (blood sample) can be arranged if this is clinically appropriate.

8.2.2.2 Covered Tests

The Precision Medicine Service arranges comprehensive genetic tests based on the cancer diagnosis subject of the request: **Somatic testing** and **Germline testing**.

1) For cancer diagnoses in early staging (classified as Stage I or II) the Precision Medicine Service will arrange genetic testing on inherited cancer risk if deemed to be clinically appropriate by an expert in this medical area designated by Further – **Germline testing.**

2) For cancer diagnoses classified according to one of the following criteria:
   - cancer that is not responding to the first line treatment (as confirmed by the treating oncologist); or
   - cancer in advanced staging (Stages III or IV); or
   - cancer of unknown primary origin (the absence of a clearly detectable primary tumour); or
   - rare forms or cancers (*).

The Precision Medicine Service arranges a comprehensive genomic test – **Somatic testing**.

(*) Cancers with an incidence of <6/100,000 included on the Surveillance of Rare Cancers in Europe (RARECAR), see www.esmo.org.

Germline testing

- **Germline testing** is a type of genetic testing that looks for inherited mutations that are present in every cell of the body and have been present since birth.
- The purpose of **Germline testing** is to identify inherited predispositions to certain types of cancers in the patient. **Germline genetic** testing results can inform cancer care by identifying patients with heritable contributions that impact cancer management and future cancer risk for second primaries. This analysis can be relevant for family members of the patient who may have inherited these same mutations.
- Testing is performed by analysing a sample in the form of a cheek swab, saliva sample or a blood draw.

Somatic testing

- **Somatic testing** is a form of genetic testing that looks for acquired mutations in a confined set of cells or tissue.
- The purpose of **Somatic testing** is to find predictors that may impact treatment decisions.
- Testing is performed by analysing a sample of the tumour in the form of a biopsy sample or liquid biopsy.

8.2.2.3 Limitations

- After reviewing the request, the appropriate Germline or Somatic test will be performed based on the qualifying criteria as stated previously in section 8.2.2.2 “Covered Tests”. One test will be performed for each unique cancer diagnosis.

  Please note:

  a. A unique cancer diagnosis is determined by the specific International Classification of Diseases (ICD) code assigned to the cancer. Therefore, the service can be requested (again) for a separate and unrelated cancer, diagnosed under a different ICD code.

  b. In the event that a specific early-stage cancer diagnosis reviewed only by **Germline testing** under this service progresses to Stage III or IV, the insured will be entitled to re-activate the service and request a **Somatic test**.

- The Precision Medicine Service may not be offered for a **pre-existing disease** or a disease present in the **exclusion period** (See section 8.6).
- The activation (and reactivation as referred to in point b) of the Precision Medicine Service must be made whilst the insurance contract is active and paid up to date.

8.2.3 Cancer treatment

Lines of treatment

The treatment of cancer is organised and administered through successive lines of treatment. Upon diagnosing cancer, the treating doctor will coordinate the “first line of treatment” (also known as initial treatment). This first line is projected to yield the greatest benefits while minimising risks and potential side effects for the majority of patients with that specific cancer diagnosis.

In cases where the initial treatment fails to produce results or triggers severe side effects, the treating doctor will initiate a second line of treatment. Additionally, as the disease progresses, it might become necessary to advance to third or subsequent lines of treatment.

Every line of treatment is formulated based on a comprehensive plan that provides exact guidelines for administering diverse treatments, such as medication cycles, medical procedures, or surgery to remove the tumour. These treatments are organised either in combination or sequentially within a specified timeframe.

Medical outcomes including Key Medication

The insurance will consider a Covered Medical Outcome to be any recommendation made in the Expert Clinical Report or the Expert Review for a line of treatment that includes a Key Medication.

In the context of this insurance, Key Medication will be considered medication that:

1. is approved by and has received a marketing authorisation from the US Food & Drug Administration (FDA) or the European Medicines Agency (EMA); and

2. is NOT listed as an approved [Godkända] medication with a sales status [Försäljnings status] of sold/available for sale [Säljs/Finns till försäljning] in Sweden by the ***Medical Products Agency (MPA) – Läkemedelsverket*** for the treatment of the form of cancer that is the subject of the claim.

Cover under this Appendix 1 includes the arrangement and payment for the specific line of treatment – that includes a Key Medication – outside of Sweden (and Norway, Finland and Denmark) for the insured residing in those countries). Cover will be provided under an "on-label" or "off-label" approach.

- **On-label approach:** The arrangement for the line of treatment where the application of Key Medication is made in accordance with the scope, dosage and administration method approved in the pharmaceutical licence issued by the relevant medical authorities in the country where the treatment is arranged.

- **Off-label approach:** The arrangement for the line of treatment where the application of Key Medication is made outside the indications approved by the relevant medical authorities in the country where the treatment is arranged.

  This can include an application for a different type of cancer diagnosis or an application in a different dose or method of administration than those detailed and approved in the pharmaceutical licence of the destination country.

  For both the "on-label" and the "off-label" approach, a preliminary medical certificate will be issued reflecting the line of treatment under the "on-label" or "off-label" approach as will be covered and performed in the selected international hospital.

8.3 Using the insurance cover offered under this Appendix 1

The conditions below apply to the provision of all cover offered under this Appendix 1, but with the detailed rules and exceptions described in the individual insurance policy. We therefore recommend that you read the terms and conditions before using the insurance.

The insurance contract provides cover under this Appendix 1 for the insured when all the following conditions are met:

- A claim is declared valid when assessed by the Precision Medicine Service following the "Claims procedure" set out in section 8.4.
- The medical treatment is arranged and paid for by this Appendix 1 for a treatment plan considered a covered line of treatment resulting from a Covered Medical Outcome as defined in section 8.2.
- The medical services and procedures offered as benefits of the insurance contract under this Appendix 1 are performed during the indemnity period. The indemnity period lasts 36 months and commences on the date of the first trip to receive treatment abroad arranged and paid for by this insurance.
- The treatment should be medically necessary and expected to cure the disorder or significantly and permanently improve the state of health. Treatments of a preventive nature are not covered. We consider medically necessary treatment to include all healthcare services or supplies, which are:
  - prescribed to the insured for the purpose of treating the cancer diagnosis that is the subject of the claim with the aim to improve the insured's medical condition; and
  - recognised as effective in improving health outcomes following treatment plans that are consistent in type, frequency and duration with the diagnosis according to published peer-reviewed medical literature (such as Pubmed) or scientifically based US, UK and/or European guidelines (specifically, NCCN Clinical Practice Guidelines in Oncology); and
  - cost-effective compared to alternative treatments that result in similar outcomes, including no treatment; and
  - required for reasons other than the convenience of the insured or his/her doctor.

  The fact that a doctor may recommend, prescribe, order or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is medically necessary under this insurance. The treatment method is covered by the insurance only if it is approved by us.

- The expenses and monetary benefits must be within the sum insured and limits stated in this Appendix 1. All expenses must be reasonable and necessary in our opinion in relation to the expected outcome. We will refer you to a clinic or private hospital for treatment abroad, and the payment will take place directly between the treatment centre abroad and us.
- The treatment is arranged by Further in accordance with the "Claims procedure" set out in section 8.4.
- The medical expenses arise outside of Sweden (and Norway, Finland and Denmark) for the insured residing in those countries) with the exception of
  - the medication expenses covered in section 8.5.4.1
  - the follow-up care expenses covered in section 8.5.4.2.
- The expenses for any medical diagnostic procedures, treatment, services, supplies or prescriptions are covered under this Appendix 1 as stated in section 8.5.
- We must always approve any examination and treatment before it begins. It is important, therefore, that you do not initiate treatment abroad without prior written approval issued via the preliminary medical certificate, as we may otherwise reject cover. This also applies if changes occur in the treatment that you have agreed with us.
- The insurance does not cover expenses for examination and treatment of a disease/injury that occurs during travel or during a stay abroad, which is unrelated to the treatment of cancer that is the subject of the claim. Please refer to section 8.5.1 for clarification on complications or side effects.
- The insurance does not pay for examination/treatment that you fail to attend or charges for late cancellation.
- Treatments that have been initiated or planned before cover under this Appendix 1 commences may not be covered. Please refer to section 8.6 for clarification on the cover for **pre-existing diseases**.
- Treatments for diseases present in the **exclusion period** may not be covered. Please refer to section 8.6 for clarification on the cover applying in the exclusion period rule.

8.4 Claims procedure

Prior to receiving any treatment, service, supply or medical prescription in relation to a valid claim, the insured or any person acting legally on his/her behalf must comply with the following procedure:

8.4.1 Making a claim

Claims must always be made during the Appendix 1 insurance period. If you are insured through an occupational scheme, you must always inform us when filing a claim if you are no longer employed by the policyholder.

Claims can be filed by contacting DSS Hälsa by telephone at +46 8 4000 6121.

The insured will then receive information about the steps required to register the potential claim through the dedicated online portal and the process for the Precision Medicine Service will be completed as outlined in section 8.4.4 “Delivery of the Precision Medicine Service”.

If you have questions about your insurance policy, you can contact the healthcare team on weekdays by telephone +46 8 4000 6121, or digitally through Mitt DSS on DSS Hälsa’s website.

8.4.2 Disclosure obligation

In addition to the completion of the Precision Medicine Service, you are required to provide the information that we find necessary in order to process the case so that we can assess the extent to which the insurance covers. We have the right to ask about your health, and you are required to provide us with all relevant information, including permission to obtain necessary information from doctors, hospitals and other therapists with relevant knowledge of your health. We can obtain the information we consider necessary, including obtaining medical records or other written material about your health. We always only collect information with your consent.

The information concerns both the period before and after the insurance enters into force.

The insured will be informed of the steps required to provide all the relevant diagnostic tests and medical documents necessary to evaluate the validity of the claim.

8.4.3 Obligation of the insured

The insured is obliged to cooperate by providing, upon the proper consent, access to medical documents in the possession of the insured or the doctors, hospitals or other medical facilities responsible for treatment up to the date the potential claim was notified.

Any claim request will only be evaluated for cover under the insurance when all the necessary information has been received from the insured and respective doctors, hospitals or other medical facilities.

8.4.4 Delivery of the Precision Medicine Service

Step 1: Intake

A request for the Precision Medicine Service can be placed through the online portal that will be available to the insured where an initial provision of medical information can be uploaded.

The insured requesting the Precision Medicine Service must provide relevant medical information which will be reviewed to assess the validity and completeness of the documentation (diagnosis, biospecimen availability, care pathway received to date, etc.) and perform a gap analysis and action plan. The insured will be supported throughout the entire process by a dedicated concierge team.

Step 2: Comprehensive genetic testing

Once the medical intake has been completed with the corresponding gap analysis and action plan, the insured will receive confirmation of the test covered.

- **Germline testing**
  For cancer diagnoses in early stages (classified as Stage I or II), an expert in this medical field designated by Further will be consulted. The expert will confirm the clinical appropriateness of **Germline testing**, in accordance with the accepted guidelines for hereditary cancer risk specific to the type of cancer in question.

  a) If **Germline testing** is not deemed clinically appropriate for the insured, an Expert Review prepared by a designated expert will be delivered to the insured. The Expert Review will offer a detailed evaluation of the diagnosis and potential treatment options.

  b) If Germline testing is deemed clinically appropriate for the insured, Germline testing will be arranged and paid under this Appendix 1.

- In the event that the findings of **Germline testing** identify in the insured a positive result for a hereditary gene, the results will be analysed by the Expert Medical Board and explained in the Expert Clinical Report (see Step 3).

- In the event that **Germline testing** does not identify a hereditary gene (a negative result), the results will be attached to the Expert Review.

The purpose of **Germline testing** is to investigate the presence of the relevant gene mutation and requires the tested individual's consent.

In the event of a positive result from **Germline testing**, each case will be assessed by a genetic counselor who will provide a report on best practices. A navigation call with the individual affected by the positive result will also be arranged to ensure a clear understanding of the information.

- **Somatic testing**
  For cancer diagnoses eligible for **Somatic testing**, the test will be arranged and paid under this Appendix 1. The results will be analysed by the Expert Medical Board and explained in the Expert Clinical Report (see Step 3).

  The most suitable specialised laboratory partner will be chosen, and the collection of the insured's sample will be arranged and paid for under this Appendix 1.

  The laboratory will perform the comprehensive genetic test including a technical review and report on the genetic profile of the individual and/or their cancer, with the cost fully paid under this Appendix 1. It is advised that the insured should not stop treatment whilst waiting for the results of any profiling tests.

Step 3: Expert Clinical Report
To review the results of **Somatic testing** or a positive result from **Germline testing**, an Expert Medical Board, consisting of a panel of specialists in oncology, genetics and pathology, selected by Further, will be engaged to deliver the Expert Clinical Report – a medical report which transforms the findings of the genetic test into clinically actionable outcomes.

Step 4: Treatment Indications and Navigation of Results
The Expert Clinical Report will provide comprehensive information and guidance regarding the outcomes of the genetic testing including:

- the clinical summary of the insured's condition
- conclusions from the genetic testing
- the optimal treatment indications available including traditional therapies, as well as novel therapies such as targeted therapies, immunotherapies or hormone therapies with the highest potential clinical benefit
- indications of resistance or toxicity to certain treatments (where applicable)
- When reviewing the results of **Somatic testing** the report will also include considerations on potential germline mutations and hereditary cancers (if applicable) and whether **Germline testing** is clinically appropriate in accordance with the accepted guidelines for hereditary cancer risk. In the event that **Germline testing** is deemed clinically appropriate, this Appendix 1 will arrange and pay for **Germline testing** of the insured.
- A navigation call is arranged between the insured and a Further case manager to fully explain and review the report outcomes.

In cases where **Somatic testing** has been reviewed and where we have the insured 's consent, their treating oncologist is invited to participate in a peer-to-peer case discussion via a virtual meeting with a member of the Expert Medical Board to discuss the outcomes of the Expert Clinical Report and ensure the results are translated into clinical practice.

Step 5: Germline testing of the family of the insured
In the event that **Germline testing** delivers a positive result for a relevant hereditary gene in the insured, this Appendix 1 will offer to arrange and pay for the **Germline testing** of eligible family members of the insured.

Please note that eligible *family members* are biological siblings and biological children of the insured who may have the potential to develop this cancer, based solely on clinical appropriateness.

8.4.5 Claim assessment and proposal of hospital for treatment

Upon receipt of

- all the relevant diagnostic tests and medical history as requested and
- the findings of the Expert Medical Report or the Expert Review resulting from the Precision Medicine Service,

Further will confirm to the insured if the claim is valid and if a covered line of treatment resulting from a Covered Medical Outcome is identified in the Expert Medical Report or the Expert Review

In the event that the insured wishes to consider treatment abroad for this covered line of treatment, the insured will be provided with a list of recommended hospitals.

In the event that the insured wishes to consider treatment abroad, Further will assess the availability of the applicable indemnity period resulting in one of the following scenarios:

- **Scenario 1: Full availability**
  There has been no previous claim under this Appendix 1 that resulted in treatment being arranged and paid for by the insurance. Therefore, Further will confirm the full availability of 36-months for the indemnity period.

- **Scenario 2: Partial availability**
  There has been one or more previous claims under this Appendix 1 that resulted in treatment being arranged and paid for by the insurance. Therefore, Further will confirm the availability of the remaining months for the indemnity period.

- **Scenario 3: The applicable indemnity period expired**
  There has been one or more previous claims under this Appendix 1 that resulted in treatment being arranged and paid for by the insurance, reaching the expiry of the indemnity period. Therefore, Further will confirm the claim is not eligible under the insurance.

Under scenarios 1 & 2, the insured will be provided with a list of recommended hospitals.

8.4.6 Treatment abroad: the preliminary medical certificate

Upon receipt of the insured's confirmation of his/her decision to receive treatment abroad at a hospital selected from the list of recommended hospitals for treatment, and provided the treatment is scheduled to commence before the expiry of the indemnity period, Further will arrange through the Medical Concierge Service the necessary logistical and medical arrangements for the correct admission of the insured, and a preliminary medical certificate will be issued valid only for that hospital.

The Medical Concierge Service is a service whereby Further, in respect of an approved claim, arranges all details relating to the medical treatment of an individual. This includes oversight of the case and assistance with travel and accommodation arrangements for the individual and any eligible companion.

The list of recommended hospitals and the preliminary medical certificate are issued on the basis of the medical condition of the insured at the time of issue. Since the health condition of the insured may change over time, both documents will have a validity of three months.

In the event that the insured does not select a hospital from the list of recommended hospitals or does not initiate treatment at the approved hospital stated in the preliminary medical certificate within three months of issue, new versions of these documents may be reissued based on the health condition of the insured at that time.

As long as the terms of the preliminary medical certificate are met, the company will, under the benefits of the insurance, directly assume the medical expenses covered and the necessary travel and accommodation arrangements subject to the limitations, exclusions and conditions detailed in the insurance.

In the event that the international doctor(s) responsible for treatment abroad decide to discontinue the covered line of treatment including the Key Medication in favour of an alternative line of treatment, the insurance contract under this Appendix will continue to cover the costs of said alternative line of treatment provided that:

- such a change is medically necessary (as assessed in the context of this Appendix 1) and
- the new line of treatment can be supported under the guidelines set out in section 8.5.1 “Medical expenses covered during treatment abroad” and section 8.6 “What the insurance does not cover”.

8.4.7 The indemnity period

The indemnity period lasts 36 months and commences on the date of the first trip to receive treatment abroad.

The insurance contract under this Appendix 1 will cover the services, expenses and monetary benefits arising in connection with this valid claim under the insurance for the duration of the indemnity period.

In the event that the insured is hospitalised or under the care of a hospital under the terms of the preliminary medical certificate as of the end of the indemnity period, the insurance will continue to provide cover for the medical expenses stated in section 8.5.1 “Medical expenses covered during treatment abroad” until the next scheduled return to the country of residence based on the established treatment plan.

8.4.8 Return from treatment abroad

In the event that the final return to the country of residence occurs before the end of the indemnity period, Further will present the insured with the guidelines to benefit from the covered medical expenses after returning from treatment abroad detailed in section 8.5.4. These guidelines will be based on the recommendations from the international doctor(s).

Under this scenario the insured will be entitled to:

- benefit from the medication expenses detailed in section 8.5.4.1 and
- benefit from the follow-up care benefit as detailed in section 8.5.4.2 until the end of the indemnity period.

8.4.9 Assessment of claims after return from treatment abroad

Upon the final return of the insured to the country of residence, after completing the treatment plan, the evolution of the insured’s state of health may determine that a new assessment for further medically necessary treatment may be required. Provided the insurance is still active and within the applicable indemnity period, the insured will be entitled to contact Further to complete this assessment.

Further will then reinform the insured of the steps required to provide Further with all the relevant diagnostic tests and medical documents necessary to complete this assessment.

In the event that the assessment by Further confirms that further medically necessary treatment is required, this will be confirmed to the insured by issuing a new preliminary medical certificate, with the resulting list of recommended hospitals and potential treatment abroad (as detailed in sections 8.4.5 and 8.4.6).

The insurance will continue to provide cover for all services and medical expenses (as detailed in section 8.5) until the end of the indemnity period under the terms of the latest preliminary medical certificate.

8.4.10 Collaboration

The insured and his/her relatives must allow visits by doctors working for Further and/or the company and any enquiries considered necessary by the company, for which purpose the doctors who have visited and attended the insured will be released from the obligation to maintain professional secrecy.

Failure to allow these visits will be considered by the company as an express waiver of the right to provide the benefits on the relevant claim covered by the policy.

8.5 Insurance cover

The insurance will cover the following services, expenses and monetary benefits arising in connection with a valid claim under the insurance.

The services must be arranged and the expenses must be incurred within the indemnity period.

This section contains the different elements of cover under the insurance:

8.5.1 Medical expenses covered during treatment abroad

The preliminary medical certificate is a written approval issued by Further, which includes confirmation of cover under the insurance contract, prior to the treatment abroad being performed at the indicated hospital, for any treatment, services, supplies or prescriptions relating to a claim.

The insurance contract will pay the following medical expenses for treatment abroad arising in connection with the medically necessary treatment of a covered line of treatment as per the terms set in the preliminary medical certificate:

1. By a hospital, in respect of:

- Accommodation, meals and general nursing services provided during the insured's stay in a room, ward or section of the hospital or in an intensive care or monitoring unit.
- Other hospital services including those provided by a hospital outpatient department (including a medical interpreter), as well as expenses relating to the cost of an extra or companion's bed if the hospital provides this service.
- The use of an operating room and all the services included in it.

2. By a day clinic or independent welfare centre, but only if the treatment, surgery or prescription would have been covered under this insurance contract if provided in a hospital.

3. By a doctor, in respect of examination, treatment, medical care or surgery.

4. For doctors' visits during hospitalisation.

5. For the following medical services, treatments or prescriptions:

   - For anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist.
   - Laboratory analysis, pathology and x-rays for treatment preparation purposes, radiotherapy, radioactive isotopes, chemotherapy, electrocardiograms, echocardiography, myelograms, electroencephalograms, angiograms, computerised tomography and other similar tests and treatments required for the treatment of a covered disease or medical procedure, when performed by a doctor or under medical supervision.
   - Blood transfusions, administration of plasma and serum.
   - Expenses relating to the use of oxygen, application of intravenous solutions and injections.
   - Radiation therapy: high-energy radiation to shrink tumours and kill cancer cells by x-rays, gamma rays, and charged particles are types of radiation used for cancer treatment either delivered by a device outside the body (external-beam radiation therapy), or by radioactive material placed in the body near cancer cells (internal radiation therapy, brachytherapy).
   - Reconstructive surgery to repair or rebuild a structure damaged or removed by the medical procedures arranged and paid for by this insurance contract.
   - Treatment for complications or side-effects directly associated with the medical procedures arranged and paid for by this insurance contract that:

     1. demand immediate medical attention in a hospital or clinical setting; and
     2. require to be addressed prior to the insured being declared medically fit to travel to return to the country of residence after the completion of the stage of treatment abroad.

6. For medication applied by medical prescription while the insured is hospitalised for treatment of a covered disease or medical procedure. Medication prescribed for post-operative treatment is covered for 30 days from the date the insured has completed the treatment abroad stage of treatment and only when these are purchased prior to returning to the country of residence.

7. For transfers and transportation by ground or air ambulances where their use is indicated and prescribed by a doctor and pre-approved by Further.

8. For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to the insured Cover will only be provided for expenses incurred from the date of issue of the preliminary medical certificate.

8.5.2 Non-medical expenses covered during treatment abroad

The insurance contract will cover the following non-medical expenses arising in connection with the travel and accommodation arrangements made by Further in order to provide the insured with access to medical treatment as per the terms set in the preliminary medical certificate.

Travel and accommodation arrangements are covered for the insured travelling companion (or two companions, when the insured receiving treatment is a minor) with each trip including the travel from the country of residence to the treatment destination and return plus the necessary accommodation arrangements for the complete duration of each trip.

The dates and duration of the trips will be established by Further on the basis of the treatment plan schedule indicated by the treating international doctor(s).

Travel and accommodation arrangements for each covered trip are covered as per the terms set below:

8.5.2.1 Travel expenses for treatment abroad

For travel outside the country of residence of the insured travelling companion (or two companions, when the insured receiving treatment is a minor) and where applicable the living donor in the case of transplant with the sole purpose of receiving treatment abroad as approved by Further/the company in the preliminary medical certificate.

All travel arrangements must be made by Further and the company will not pay for any travel arrangements made by the insured or any third party on the insured's behalf.

Further will be responsible for deciding the travel dates for each covered trip based on the approved treatment schedule. These dates will be communicated to the insured to allow for sufficient time for the insured to make all the necessary personal arrangements.

In the event that the insured changes the travel dates from those communicated by Further/the company, the insured will need to compensate the company and/or Further for all the associated costs of organising and providing new travel arrangements, unless the changes have been confirmed by Further as necessary from a medical standpoint.

The travel expenses covered will include:

- Transportation from the insured's permanent address in Sweden, Norway, Finland or Denmark to the designated airport or international rail station.
- Economy class rail or air ticket to the city of treatment destination and the transportation to the designated hotel.
- Transportation from the designated hotel or hospital to the designated airport or international rail station
- Economy class rail or air ticket and subsequent transportation to the city of the insured's permanent address in Sweden, Norway, Finland or Denmark.

The travel expenses covered will not include regular transfers from the hotel to the hospital or treating doctor during the duration of the treatment abroad.

8.5.2.2 Accommodation expenses covered during treatment abroad

Expenses are covered for accommodation outside the country of residence of the insured, the travelling companion (or two companions, when the insured receiving treatment is a minor) and the living donor in the case of transplant, where the sole purpose is to receive treatment abroad as approved by Further/the company in the preliminary medical certificate. All accommodation arrangements for each covered trip must be made by Further, and Further/the company will not pay for any accommodation arrangements made by the insured or any third party on the insured's behalf.

Further will be responsible for deciding the accommodation booking dates for each covered trip based on the approved treatment schedule. These dates will be communicated to the insured to allow for sufficient time for the insured to make all the necessary personal arrangements.

Further will provide a return date for each covered trip based on the agreement with the treating doctor that the insured is fit to travel.

In the event that the insured changes the dates of travel from those booked and communicated by Further, the insured will need to compensate the company and/or Further for all the associated costs of organising and providing new accommodation arrangements, unless the changes have been confirmed by Further as necessary from a medical standpoint.

The accommodation arrangements will include:

- Bookings for a double room or twin bedroom in a three or four-star hotel, including breakfast.

  (The choice of hotel will be subject to availability and based on the proximity to the hospital or treating doctor within a radius of 10 km).

8.5.2.3 Repatriation expenses

In the event that the insured (and/or living donor in the case of transplant) dies outside the country of residence while receiving treatment abroad, the company will pay for the repatriation of the deceased's remains to the country of residence.

This cover is limited to only those services and supplies necessary to prepare the deceased's body and transport to the country of residence, including:

- The services provided by the funeral company providing the international repatriation, including embalmment and all administrative formalities.
- The minimum obligatory coffin.
- The transport of the deceased's remains from the airport to the designated place of burial in the country of residence.

8.5.3 Monetary benefits covered during treatment abroad

During treatment abroad as approved by Further/the company in the preliminary medical certificate and for each overnight stay in a hospital or clinic, the insurance contract under this Appendix 1 will pay the insured the daily hospitalisation indemnity, up to the following limit:

The daily hospitalisation indemnity pays the insured 1,100 SEK for each overnight stay in a hospital or clinic limited to 60 days per claim.

The confinement must be approved by Further/the company in the preliminary medical certificate.

8.5.4 Treatment expenses covered after returning from treatment abroad

8.5.4.1 Medical expenses covered after returning from treatment abroad

After returning to the country of residence from treatment abroad, the insurance contract will pay for medication expenses prescribed and purchased in the country of residence, subject to the following conditions and limitations:

1. The medication has been licensed and approved by the corresponding medical authority or agency in the country of residence, and its prescription and administration are regulated; and

2. The medication is available for purchase in the country of residence in a time and manner necessary for the continuation of the treatment; and

3. The medication requires prescription by a doctor in the country of residence; and

4. The medication is recommended by Further following the recommendations of the international doctor(s) that treated the insured, as necessary for on-going treatment; and

5. The medication is following a hospitalisation outside of the country of residence of at least three overnight stays approved by Further/the company in the preliminary medical certification; and

6. Each prescription does not exceed a dose for consumption longer than 2 months; and

7. All prescriptions are issued prior to the end of the indemnity period.

The purchase of the medication for this section 8.5.4.1 when performed in the country of residence needs to be arranged and paid for directly by the insured. The company will reimburse the insured upon receipt of the relevant prescription, original invoice and proof of payment, provided those invoices are submitted to the company not more than 180 days after the date the expense was incurred.

Where the cost of medication has been funded in part or in full by the public health service of the country of residence or an insurance established with DSS Hälsa, the company will only reimburse the costs that are not funded and thus have to be paid directly by the insured. The reimbursement request should clearly differentiate those costs that are directly paid by the insured from the funded part.

In the event that the recommended medication (or alternative equivalent medication with a similar effectiveness), as confirmed by Further:

- is not licensed or approved in the country of residence as mentioned in above condition (1), or
- is not available for purchase or accessible to the insured in the country of residence, as mentioned in above condition (2), and
- all other conditions (4) through (7) above are still met, the insurance contract will also pay for medication expenses outside of the country of residence.

In this event, Further will arrange the necessary travel and accommodation arrangements on the terms described in section 8.5.2 for the insured and designated companion(s).

Medication expenses are covered in this section 8.5.4.1 up to the limit of 550,000 SEK per insured in the lifetime of this Appendix 1.

8.5.4.2 Follow-up care returning from treatment abroad

In the context of this insurance, follow-up care refers exclusively to any diagnostic investigation and/or monitoring/surveillance service (by a doctor with special expertise referring to the treated disease) post treatment abroad, used to identify whether the insured is suffering (or likely to suffer) from a deterioration or complication of the treated disease, with the purpose of preventing relapses or recurrences of the same disease.

After returning to the country of residence having completed the stage of treatment abroad, the insurance contract will cover expenses arising from follow-up care incurred in the country of residence, subject to the following conditions and limitations:

1. The follow-up care has been performed in one of the hospitals selected by Further; and
2. The follow-up care is available in the country of residence in a time and manner necessary for the ongoing screening; and
3. The follow-up care is performed following the recommendations of the international doctor(s) that treated the insured, as necessary for ongoing screening and monitoring; and
4. The follow-up care related invoices are issued prior to the end of the applicable indemnity period.

Follow-up care under section 8.5.4.2 when performed in the country of residence needs to be arranged and paid directly by the insured in the country of residence.

The company will reimburse the insured upon receipt of the original invoice and proof of payment, provided those invoices are submitted to the company not more than 180 days after the date the expense was incurred.

In the event that the doctors responsible for arranging follow-up care in the country of residence indicate, following the evolution of the insured's state of health, the need to work on the basis of different follow-up care guidelines from those initially established by the international doctor, Further will communicate these to the international doctor for approval and confirm, when applicable, the reimbursement of such expenses following the new, accepted guidelines.

Where the cost of follow-up care has been funded in part or in full by the public health service of the country of residence or an insurance established with DSS Hälsa, the company will only reimburse the costs that are not funded and thus have to be paid directly by the insured. The reimbursement request should clearly differentiate those costs that are directly paid by the insured from the funded part.

At the request of the insured and provided previous conditions (3) and (4) are still met, Further can also authorise and arrange follow-up care outside the country of residence. In this event:

- Follow-up care will be performed by the international doctor(s) that treated the insured or their medical team.
- The company will directly assume the medical expenses of these consultations and diagnostic tests.
- Further will make the necessary travel and accommodation arrangements on the terms described in section 8.5.2 for the insured and designated companion(s).

8.6 What the insurance does not cover

Cover under this Appendix 1 does not cover examination, treatment and other expenses for:

- Emergency treatment and acute situations that require rapid assistance and cannot await scheduled treatment abroad.
- Preventative examinations, health checks prior to the suspicion of a disease and any other form of preventive controls, including surgery for prophylactic purposes.
- Cosmetic treatments and procedures and their consequences, with the exception of breast reconstruction surgery performed after mastectomy surgery arranged and paid for by this insurance contract under Appendix 1.

- Any medical consequence of abuse of medicine, alcohol, narcotics or other intoxicants.
- A 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 or participation in criminal offences. Injuries caused by non-compliance with healthcare recommendations.
- Injury/disease caused 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, pandemics, viral infections and related vaccines.
- A claim where, prior to, during or after the claim assessment process established by Further, the insured:
  - has not followed the advice, prescriptions or established treatment plan of the treating doctor; or
  - refuses to receive any medical treatment or be subject to additional diagnostic analysis or tests necessary to establish a definitive diagnosis or treatment plan.
- Medical treatment involving Gene Therapy, Somatic-Cell Therapy, Tissue-Engineered Therapy with the exception of CAR T-Cell Therapy delivered under the CAR T-cell Approved Protocol.
- Experimental treatment as well as those diagnostics, therapeutic and/or surgical procedures whose security and reliability have not been widely recognised by the international science community as safe, effective and appropriate for the treatment of the disease in question or is at any stage of clinical experimentation with the exception of a valid claim request for an off-label approach as recommended in the Expert Clinical Report or in the Expert Review.
- Medical procedures needed as a result of AIDS (acquired immune deficiency syndrome), HIV (human immunodeficiency virus) or any condition arising from them (including Kaposi's sarcoma), or any treatment for AIDS or HIV.
- Any health care service or supply that is not medically necessary.
- Any disease or medical condition, which has been caused by the medical procedures arranged and paid for by this Appendix 1 save where the disease or medical condition in question is a covered disease.
- Treatment for long-term side effects, relief of chronic symptoms or rehabilitation (including but not limited to physiotherapy, mobility rehabilitation, and language and speech therapy).

- In relation to the medication expenses (section 8.5.4.1), the following exclusions apply:
  - Any cost funded by the public health service of the country of residence or covered by any other insurance established with DSS Hälsa.
  - The cost of the administration of the medication in the country of residence.
  - Any purchase of medication incurred outside the country of residence unless explicitly authorised by Further/the company.
  - Invoices submitted for reimbursement to the company more than 180 days after the date the expense is incurred.
- In relation to the follow-up care expenses covered as detailed in section 8.5.4.2, the following exclusions apply:
  - Any cost funded by the public health service of the country of residence or covered by any other insurance established with DSS Hälsa.
  - Any expense incurred that does not follow the guidelines established by Further.
  - Any expense incurred in a different hospital or medical facility from that authorised by Further.
  - Invoices submitted for reimbursement to the company more than 180 days after the date the expense is incurred.
- Medical treatment for a line of treatment involving a transplant with the exception of Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the insured originating from:
  - the insured (autologous bone marrow transplant); or
  - from a living compatible donor (allogeneic bone marrow transplant).

  Please note that Haemopoietic Stem Cell transplantation (HCT) using the umbilica cord blood will be excluded.
- Any expenses incurred in connection with or derived from any diagnostic procedures, treatment, service, supply or medical prescription of any nature incurred in the country of residence with the exception of:
  - the medication expenses covered in the country of residence, section 8.5.4.1
  - the follow-up care expenses covered in the country of residence, section 8.5.4.2.

- Any expenses incurred in connection with or derived from any diagnostic procedures, treatment, service, supply or medical prescription of any nature incurred worldwide when, at the point of the relevant claim notification date, the insured cannot be considered a permanent/legal resident in any of the accepted territories: Sweden, Norway, Finland or Denmark.
- Any expenses incurred outside the indemnity period with the exception of those stated under section 8.4.7.
- Any expense incurred before the issuance of the preliminary medical certificate.
- Any expense incurred in a different hospital from that authorised and mentioned in the preliminary medical certificate.
- Any expense incurred without following section 8.4.
- Any expense incurred in respect of confinement services, health resorts, nature cure clinics, home health care or services provided in a convalescence centre or institution, hospice or old people's home, even where such services are required or necessary as a result of a covered disease or medical procedure.
- Any expense incurred in the purchase (or hire) of any type of prosthesis or orthopaedic appliances, corsets, bandages, crutches, artificial members or organs, wigs (even where their use is considered necessary during chemotherapy treatment), orthopaedic footwear, dentures, trusses and other similar equipment or items, with the exception of breast prostheses after mastectomy surgery needed as a result of surgery arranged and paid for by this Appendix 1.
- Any expense incurred in the purchase or hire of wheelchairs, special beds, air conditioning appliances, air cleaners and any other similar items or equipment.
- Any medication not dispensed by a licensed pharmacist or obtainable without a medical prescription.
- Any charges made for the use of alternative medicine, even when specifically prescribed by a doctor.
- Any charges for medical attention or confinement in cases of cognitive disorders, senility or cerebral impairment, regardless of the status of their development.
- Interpreter's fees, telephone and other charges in respect of items for personal use or which are not of a medical nature, or for any other service provided to relatives, companions or escorts.
- Any expense incurred by the insured or the relatives, companions or escorts, except those expressly covered.
- Any medical expense that is not a customary and reasonable charge.

- Any expenses in respect of accommodation or transportation arranged by the insured travelling companion or a living donor.
- For any insured that is added to the cover of this insurance contract on a voluntary basis after the ***Cancer Care start date***, cover under this Appendix 1 comes into effect on the date they are included in the contract, but certain cover exclusions will apply:

  a) pre-existing diseases are not covered and

  b) cover is also not provided for any disease or medical condition that was reported, diagnosed or treated or that presented its first related medically documented symptoms or findings (signs) during the exclusion period.

8.7 Special provisions

General terms apply to the provision of cover under this Appendix 1 unless a special term is stated below:

8.7.1 Cover on termination of the insurance

When the insurance stops, you lose the right to cover and no new claims can be reported.

If the insured party is hospitalised or under the care of a hospital as per the terms of the preliminary medical certificate at the termination of the insurance, cover will continue based on the terms of this last preliminary medical certificate for a period of three months after the termination of the insurance or the next scheduled return to the country of residence, whichever occurs earlier.

This section 8.7.1 overrules any indication made in section 1.10 Post-employment cover.

8.7.2 Continuation insurance

No continuation insurance is granted for Cancer Care cover.

This section 8.7.2 overrules any indication made in section 1.11 Continuation insurance.

8.7.3 Transfer from another group or insurance company

Cancer Care cover is included in the transfer scenario discussed in section 1.5.3 Group transfer within the company.

Cancer Care cover transfer is not guaranteed for the transfer scenarios Voluntary group transfer and Mandatory group transfer stated in sections 1.5.1 and 1.5.2, respectively.