Terms – Private

Health Insurance Flex

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DANSK SUNDHEDS SIKRING

Table of Contents

1. Basis for the agreement 3
1.1 When does the insurance apply 3
1.2 What the insurance covers 3

2. Who the insurance covers 4
2.1 Co-insured 4
2.2 Qualifying provisions 4

3. What the insurance covers 4

4. Using the insurance 5
4.1 Doctor's referral 5
4.2 Examination and treatment must be approved 5
4.3 Acute treatment is not covered 5
4.4 Travel and stays abroad 5
4.5 Non-appearance for treatment 5
4.6 Ongoing and planned treatment 5
4.7 Expenses for treatment 5
4.7.1 Rates for physiotherapy, chiropractic, osteopathy and treatment by a psychologist 6
4.8 Choice of therapist 6
4.9 Assessment of treatment requirements 7
4.10 Making a claim 7

5. What the insurance covers 8
5.1 SundhedsNavigator (Health Navigator) and health professional advice 8
5.2 Rapid examination 8
5.3 Medical second opinion by our specialists 9
5.4 Online emergency medical service 10
5.5 Multidisciplinary treatment of musculoskeletal disorders 11
5.6 Addiction counselling 11
5.7 Online/digital treatment of mental disorders 11
5.8 Trauma counselling 12
5.9 Hotline for stress and well-being 12

6. What the insurance does not cover 13

7. General provisions 14
7.1 Duration of insurance 14
7.2 Insurance sum 14
7.3 Payment of the premium 14
7.4 Adjustment of premium and insurance conditions 15
7.5 Cancellation and termination of the insurance 15
7.6 Disclosure obligation 16
7.7 Processing of personal information 17
7.8 Processing of health information 17
7.9 Incorrect information 17
7.10 Limitations 17
7.11 Avenues of complaint 17
7.12 For further information 18
7.13 Right of cancellation 18

DANSK SUNDHEDS SIKRING

1. Basis for the agreement

These insurance conditions are valid from 1 January 2024.

The insurance is established in Forsikringsselskabet Dansk Sundhedssikring A/S, VAT no. DK34739307 – hereinafter referred to as Dansk Sundhedssikring A/S.

The overall contract on insurance with Dansk Sundhedssikring A/S is comprised of the insurance contract (the policy), any addenda to the insurance contract and the insurance conditions attached to the insurance contract. The insurance is also subject to Danish law, including the Insurance Contracts Act and the Financial Business Act.

The insurance contract applies between Forsikringsselskabet Dansk Sundhedssikring A/S and the person named as the policyholder.

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

Company
This means Forsikringsselskabet Dansk Sundhedssikring A/S, referred to in the conditions as “Dansk Sundhedssikring”, “we” and “us”.

The insurance period
The insurance period is the period from when the insurance enters into force until it ends, for whatever reason.

Policyholder
The person with whom we have entered into the insurance contract.

Insured party
The person covered by the insurance often referred to as you/yours in the following.

1.1 When does the insurance apply
The insurance applies during the insurance period. The insurance will come into effect at the time agreed between the policyholder and Dansk Sundhedssikring.

1.2 What the insurance covers
The insurance covers the examination and treatment of diseases, injuries and disorders that are likely to be cured or significantly and permanently improved by treatment. We define diseases as medical conditions, disorders or injuries that are symptomatic and which we assess to cause a medically motivated need for examination or treatment.

Forms of treatment
We can refer you to several different therapies and treatment options to ensure optimal and flexible treatment of your problem. This can be digital/online treatment or physical attendance by a therapist. We assess which examination or treatment is necessary.

2. Who the insurance covers

The insurance can be taken out by private individuals who have reached the age of 18 and under the age of 66.

The insurance expires at the renewal date the year you turn 67.

The insured party must have a permanent National Registration Office address in Denmark (excluding Greenland and the Faroe Islands), must have a Danish health insurance card and be entitled to receive Danish public health insurance benefits. Exceptions will be stated in the contract.

If you are working abroad, you are only covered for examination and treatment in Denmark. Transport costs to and from Denmark are not covered.

2.1 Co-insured

It is possible to co-insure children for a separate price. Children who can be subscribed are your biological children and/or adoptive children and your spouse's/cohabitant's biological children and/or adoptive children who have their National Registration Office address with you. A spouse's/cohabitant's biological children and/or adoptive children, who do not have their National Registration Office address with you, can be co-insured if your spouse/cohabitant has taken out an insurance. Children can be co-insured until their 24th birthday. The insured party must always notify us if changes occur in their relationships that affect who should be covered by the insurance contract.

2.2 Qualifying provisions

There is a 6-month qualifying period for existing diseases, injuries and disorders. This means that you must have been covered by the insurance for 6 months before expenses for examination and treatment of disorders that arose and/or were diagnosed before the insurance came into force are covered. Diseases and injuries that arise after the insurance comes into force will be covered on the basis of the applicable insurance conditions.

Seniority from other health insurance can be transferred in case of direct transition without delay from other health insurance. However, this does not apply to chronic disorders, unless otherwise stated in the contract.

3. What the insurance covers

The insurance covers examination and treatment in Denmark, and we refer to a digital/online treatment option or a treatment centre in the public or private healthcare system, unless otherwise stated in the individual cover.

The choice of treatment centre must always be by agreement with us, and we can decide that it should be performed at a particular therapist or at a particular treatment centre. For some forms of treatment, however, you can choose the therapist yourself. This will be stated in the individual coverage.

4. Using the insurance

The overall conditions apply to all cover, but with the detailed rules and exceptions described in the individual cover. We therefore recommend that you read the terms and conditions before using the insurance.

4.1 Doctor's referral
Unless otherwise stated in the cover, you must have a doctor's referral or recommendation describing the disease/injury before using the insurance. The doctor's referral must be available before an examination or treatment can commence. You must therefore start by consulting your own doctor, who will best evaluate your treatment needs. If your doctor considers that you require examination or treatment, you should be referred for treatment in the public health service if possible. You can use this reference when you report the claim to us.

4.2 Examination and treatment must be approved
We must always approve all examination and treatment before it begins. It is important, therefore, that you do not initiate treatment without prior written approval, as we may otherwise reject cover. This also applies if changes occur in the treatment that you have agreed with us.

4.3 Acute treatment is not covered
Acute treatment and emergency situations are not covered by the insurance, including examination and treatment that requires assistance and cannot wait for scheduled treatment. This applies to e.g. traffic accidents, accidents, fractures, strokes, brain haemorrhage, heart disease and other diagnosis areas that we and/or the public sector define as acute, including cancer treatment packages, life-threatening cancer and ischaemic heart disease. If you need emergency care, including a casualty ward or ambulance, you should always contact your own doctor, the emergency medical service, the emergency telephone line, casualty ward or 112. The insurance covers the costs of psychological treatment for emergency trauma counselling.

4.4 Travel and stays abroad
The insurance does not cover expenses for examination and treatment of a disease/injury that occurs during travel or during a stay abroad. Treatment will only be covered after you return home to your permanent residence and on the basis of the general conditions. This also applies if you are staying in Greenland or the Faroe Islands.

In a number of cases, we can refer to digital/online treatment based on a professional assessment. The digital treatment options and online medical assistance can be used in Denmark and during stays abroad.

4.5 Non-appearance for treatment
The insurance does not pay for examination/treatment that you fail to attend or charges for late cancellation.

4.6 Ongoing and planned treatment
Treatments that have been initiated or planned before this insurance commences are not covered. If you have reported a claim to your former insurance company, we will only cover the claim after 3 months from the date you enter into the arrangement with us, unless otherwise stated in the agreement. When we take over a claim from your former insurance company, it will be covered on the basis of our current insurance conditions.

4.7 Expenses for treatment
All expenses must be reasonable and necessary in our opinion in relation to the expected outcome. The insurance covers your actual expenses after contributions from the public health insurance system are deducted. This means that in cases where public health insurance covers a portion of the cost, we will offset that portion and pay your share (self-payment). If you are a member of Sygeforsikringen "danmark", then we will receive and offset your possible subsidy for the treatment.

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In cases where we refer to a private clinic or private hospital for examination, the payment will usually take place directly between the treatment centre and us.

We do not cover expenses that the public sector has already fully or partially covered or that the public sector has offered to cover, but where the date of examination or treatment did not suit you, for whatever reason.

4.7.1 Rates for physiotherapy, chiropractic, osteopathy and treatment by a psychologist

You must have a valid referral from your doctor for physiotherapy and use a therapist who has an agreement with the public health insurance (service provider number), unless otherwise stated in the individual cover.

If you choose a therapist without an agreement, the therapist's fee will be covered up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the agreement's index-adjusted rates.

For chiropractic treatment, the amount corresponding to the patient's share is covered according to the rate applicable for general chiropractic.

For osteopathy, we cover the therapist's fee, up to a maximum of DKK 650 for the first treatment and DKK 500 for subsequent treatments.

Psychological treatment takes place digitally/online in our quality-assured network, and we settle with the therapist.
Other treatment rates are stated in the individual cover.

4.8 Choice of therapist

The treatment should, in our opinion, be expected to cure the disorder or significantly and permanently improve the state of health.

Only treatments that are approved by the public health authorities in Denmark and are in accordance with national clinical guidelines, and are frequently used in public health care are covered. The treatments must be conducted using methods with proven effect and must be included in the agreement with the public health insurance.

All treatments must be performed by healthcare professionals authorised by Danish law, unless otherwise provided by the individual cover.

We use an approach where we strive to adapt the form of treatment based on evidence and flexibility. It can be instruction in exercises, video consultations or physical consultations at a clinic.

The insurance only covers the types of treatment mentioned in the insurance conditions under the various covers.
We typically recommend treatment in our quality-assured nationwide network. However, you have the option to choose a therapist yourself.

Treatment of mental disorders is always covered digitally in our quality-assured network.

For examination by a medical specialist, the first examination will be initiated within 10 working days in the public or private healthcare service. We select the therapist/treatment centre.

The treatment method must always be approved by us. No costs are covered for examination or treatment performed by you, your family members or any company belonging to any of these.

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4.9 Assessment of treatment requirements

Examination and treatment must always be medically justified, and you must have a written referral or a doctor's recommendation unless otherwise stated in the cover.

Our health team consisting of experienced nurses, doctors, physiotherapists and other healthcare professionals treats and evaluates all injuries and claims. The healthcare team determines whether the reported disease/injury is covered and they assess which examination or treatment is necessary.

Only one course of treatment at a time is covered. If necessary, based on a health assessment, we can choose to cover multiple courses of treatment simultaneously.

You are required to provide us with the information we consider necessary to make our decision, e.g. a doctor's referral or a copy of medical records. As part of our assessment of whether a claim is covered or whether the costs are reasonable, we may require that a new assessment is conducted by a doctor designated by us.

4.10 Making a claim

Claims must always be made during the insurance period. The quickest way to file a claim is by reporting it online via our website: ds-sundhed.dk. Claims filed will be treated quickly and, in most cases, from one day to the next. Claims can also be filed by telephone. If you have questions about your insurance policy or if your inquiry concerns an existing case, you can contact the healthcare team via Mit DSS on our website: ds-sundhed.dk.

Trauma counselling

If your claim concerns emergency trauma counselling, you can contact us 24 hours a day by telephone +45 70206121. If you call outside of our opening hours, you will be redirected to our emergency line via the main number. You must always inform the on-duty staff that you are insured with Dansk Sundhedssikring.

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DANSK SUNDHEDS SIKRING

5. What the insurance covers

This section contains the various basic covers. The overall insurance conditions apply to all sections, but with the special rules and exceptions that apply to each cover.

The covers are described in the following sections:

5.1 SundhedsNavigator (Health Navigator) and health professional advice

Our healthcare team consisting of experienced doctors, nurses, physiotherapists and other healthcare professionals has many years of experience in various areas of specialisation and they offer professional advice on health and disease.

You are offered consultation with a nurse, physiotherapist or doctor by telephone for all health problems, including those that do not require actual treatment or which are not covered by the insurance.

The healthcare team can help with counselling on health and wellness, problems with well-being, stress and stress prevention, substance abuse, pain, pregnancy, courses of treatment and management challenges.

Our healthcare team has in-depth knowledge of both public and private healthcare.

Through our unique SundhedsNavigator and co-ordinator concept, we offer you help to organise and carry out the course of examinations and treatments, as well as provide guidance on the public health care system's treatment options, e.g. patient rights, complaint procedures, guidance regarding waiting times, free choice of hospital and examination and treatment guarantees. We also help you review medical records from hospitals and doctors, book appointments for treatment or examination, arrange transportation or other assistance if necessary.

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

5.2 Rapid examination

The insurance covers reasonable examinations carried out by the relevant specialist doctor in a hospital or clinic, which we consider necessary to make a diagnosis. The examination can take place upon a written referral from your own doctor. Relevant examinations by a specialist are covered until a diagnosis has been made, e.g. any diagnostic imaging examinations, laboratory tests, etc.

If the examination does not lead to a diagnosis, the examination process is completed when we assess that all relevant investigations have been carried out. The subsequent course of treatment must take place in the public sector. The insurance does not cover further examination/diagnosis of symptoms where we have previously covered the examination of the same condition/injury or where the same examination/diagnosis has previously been carried out or made within a public or private setting. In this case, please refer to the insurance offer for a medical second opinion.

In relevant cases, the insurance covers the costs of one therapeutic blockade treatment carried out by a relevant specialist appointed by us in cases where we assess that the blockade treatment can significantly and permanently reduce the suffering.

You are guaranteed that a coverable examination will be initiated within 10 working days in the private or public healthcare system, after we have received and approved your notification. If we need more information, such as a doctor's referral, the 10 working days start after we have received and approved the necessary information.
If we consider that it is not possible for you to obtain an appointment within 10 working days in the public health service,

including a free choice of hospital and activation of the right to timely examination and treatment, we may instead refer you for examination at a private hospital or a private clinic in our network. You must always use the treatment centre we refer you to. In cases where the waiting time in the private healthcare system is the same as in the public system, we can choose that the public system should be used.

We can at any time request medical records, referrals or certificates that we consider necessary for our healthcare assessment, including about the reported condition covered by the health scheme.

Skin conditions
The insurance covers reasonable examinations carried out by the relevant dermatologist in a hospital or clinic, which we consider necessary to make a diagnosis. The examination can take place upon a written referral from your own doctor. The insurance covers examination of skin conditions which we consider are affecting your health condition. Examination of skin diseases that we consider cosmetic are not covered. Examination of recurring skin disorders or relapses, e.g. elsewhere on the body, is not covered.

The subsequent course of treatment must take place in the public sector. In relevant cases, the insurance covers the removal of suspected malignant moles as part of the examination process.

Cancer
The insurance covers the examination of cancer. If the waiting period for the examination in the public healthcare system is at the same level as in the private sector, the public system must always be used. In case of cancer diseases that form part of a comprehensive treatment package in the public healthcare system, the public offer must always be activated and used.

The examination guarantee does not cover:

- If the public healthcare system has offered you or has the opportunity to offer you an appointment within the guarantee period of 10 working days, but where that date does not suit you, regardless of the reason for this.
- If you reject, in whole or in part, an offer for an examination in the private or public healthcare system, e.g. because you want a different treatment centre than the one designated.
- If you express a wish for an examination at a later date than the period of the examination and treatment guarantee.
- If we consider that it is not medically appropriate to initiate an examination within 10 working days.
- If an approved and scheduled examination or treatment is postponed for medical reasons.
- If we consider that the treatment is highly specialised and should be performed in the public system, e.g. in case of special disease diagnoses, complicated diseases, or if you are in the process of a prolonged examination process in the public system.
- In case of major conflicts and/or limited capacity in the public healthcare system and unpredictable occurrences beyond our control. In these cases, we are entitled to a reasonable extension of the guarantee.

5.3 Medical second opinion by our specialists
If you have previously been investigated and diagnosed for the same problem that you are contacting us with, we offer a review of medical records, referrals and medical documents as well as advisory consultation with our doctors and nurses by telephone. This also applies if two doctors disagree about your diagnosis or form of treatment (third opinion).

DANSK SUNDHEDS SIKRING

5.4 Online emergency medical service

Necessary health consultations are covered by private emergency medical service for the entire household, i.e. the insured, spouse/cohabitant and the children of the household that are living at home under the age of 24.

Online emergency medical service is a supplement to your general practitioner and offers quick access to email and video consultations with a private emergency service outside normal opening hours. The emergency medical service is operated by experienced specialists in general medicine and can provide medical advice and guidance as well as answer questions about illness and disease symptoms that do not require a physical examination. The emergency medical service can also prescribe and renew most prescriptions, provide guidance on over-the-counter medicines, and refer you to regional public hospitals.

For example, you can get help for inflammation of the middle ear, sinusitis, eye inflammation, colds and influenza, headaches and migraines, muscle and joint pain, asthma, allergies, sores, skin rashes and eczema, vomiting and diarrhea, urinary tract infection, sleep problems, mental disorders, contraception, pregnancy and breastfeeding, and sick children with fever. In the event of an acute illness or acute exacerbation of an existing illness, you should immediately contact the emergency medical service/1813 or 112.

In cases where the doctor deems it necessary, the doctor will refer you to your own doctor, the emergency medical service or a public hospital. For example, if a physical examination, blood tests or questions regarding an ongoing course of treatment is needed.

The medical emergency service can only refer to a public hospital or emergency room in cases where a medical assessment deems it necessary. The medical emergency service cannot refer for diagnostic imaging. Transport in connection with any hospitalisation is not covered. The emergency medical service can only arrange transport in the event of an emergency admission via 112.

The emergency medical service does not prescribe drugs that are addictive or drugs with the potential for abuse, e.g. sleeping pills, sedatives, and morphine. Based on a professional assessment, the emergency medical service can always choose not to prescribe medication and instead refer to a public treatment option.

The emergency medical service cannot issue doctor’s notes as well as medical certificates in connection with driving licenses, activities, and health checks, as this requires a physical examination.

The emergency medical service cannot answer questions about the health insurance, and no private referrals can be made for specialist medical practice, psychological treatment, physiotherapy, etc. Consultations with private emergency medical services outside our network are not covered.

How to use the medical service

The emergency medical service is operated by experienced doctors on weekdays as well as weekends and holidays. It is quick and easy to use the medical service using a computer, tablet, or smartphone. You can make an appointment when it suits you or wait for a doctor to become available. You also have the option to write to the doctor 24 hours a day.

During opening hours, you will receive an answer within one hour. The emergency medical service can be used in Denmark and during stays abroad.

When you use the emergency medical service, you are data protected and we do not have access to information regarding what you have discussed with the doctor. You can read more about using the medical service via our website: ds-sundhed.dk.

5.5 Multidisciplinary treatment of musculoskeletal disorders
The insurance covers new and existing pain and discomfort in the musculoskeletal system that has arisen in your spare time or because of your work, including arm and leg pain, sciatica and headaches caused by muscle tension in the back and neck. The musculoskeletal system refers to the joints, muscles and tendons of the back, shoulders, neck, knees, hips, elbows and wrists.

You can get treatments from a physiotherapist, chiropractor or osteopath.

Physiotherapy and chiropractic treatment are covered for coverable musculoskeletal disorders. Cover is provided for the number of reasonable and necessary treatments that can be justified for healthcare reasons, up to a maximum of 12 treatments per calendar year. You can choose which therapist to use. For treatment by a physiotherapist, we can also refer you to online treatment in our quality-assured network.

Osteopathy is covered for a coverable disorder in the musculoskeletal system with a maximum of 5 treatments per calendar year.

Our health team consisting of experienced nurses, doctors, physiotherapists and other healthcare professionals treats all claims and evaluates which treatment should be used. One course of treatment is covered at a time. If necessary, you can receive a combination of treatments.

After a professional assessment, we can either refuse to cover a treatment if the problem cannot be rectified, or stop a treatment course if the treatment is deemed to be ineffective.

You are required to provide us with the information we consider necessary to assess whether the injury is covered by the insurance and whether the treatment has the desired effect. If it is necessary for health reasons, we may ask for a referral or recommendation to further identify your problem.

5.6 Addiction counselling
If you have an addiction to alcohol, medication, drugs, etc., you can call our healthcare team for advice. The healthcare team can also advise you about public treatment services.

5.7 Online/digital treatment of mental disorders
The insurance offers individual counselling or treatment for mental disorders arising in your spare time or because of your work by psychologists and psychotherapists with special expertise in areas such as stress, well-being, anxiety, depression, bullying and workplace conflicts.

We can refer you to consultations with experienced therapists via various online or digital treatment options, such as video consultation, telephone sessions or via any other digital platform in our quality-assured network.

The insurance covers the necessary number of treatments/consultations per disease/injury based on a professional assessment. Recurrent disorders previously treated under the insurance are not covered.

Treatments of a preventive or maintenance nature are not covered.

Treatment of serious or enduring mental disorders requiring long-term or specialised treatment is not covered, see section 6 “What the insurance does not cover”.

5.8 Trauma counselling

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

- If you have experienced a sudden serious incident/accident, where you have been in danger.
- If you are subjected to a robbery, assault, violence or kidnapping.
- Fire, explosion or burglary in your private residence or your own business (must be reported to the police).
- If you are diagnosed with a life-threatening disease.
- Death within your immediate family.
- If a member of your immediate family is diagnosed with a life-threatening disease.
- If you experience a family member's or colleague's sudden, unexpected death or sudden serious incident/accident.

Immediate family members refers to a spouse, cohabitant, own children, a spouse's/cohabitant's children and adopted children.

There is no requirement for a doctor's referral. The healthcare team assesses whether emergency trauma counselling is required or whether other treatment is required. If we consider that you need emergency trauma counselling, we will find a psychologist for you in our network. You will have telephone contact with the psychologist within 3 hours after the notification is approved. The subsequent process will depend on the nature of the incident and the therapist's professional assessment.

In case of notification more than 48 hours after the cause of the crisis, cover for ordinary psychological counselling will always apply.

Emergency psychological counselling abroad is not covered.

Debriefing of groups is not covered, unless it is included as part of the cover for an approved emergency course of treatment.

5.9 Hotline for stress and well-being

With a health insurance policy at Dansk Sundhedssikring, you can call and get personal advice, guidance and support for stress and well-being-related problems that do not require actual treatment.

The hotline for stress and well-being is managed by an experienced, in-house counselling team, all of whom have a professional background within health and can help you prevent and manage problems before they become major issues.

Here you can get quick and personalised counselling and help to safeguard your mental health – already at the early signs of stress and problems with well-being. The counselling covers, e.g.:

- Reduction and prevention of early signs of stress and dissatisfaction with life.
- Private wellness issues, such as personal crises, children, cohabitation, divorce, lifestyle and substance abuse.
- Work-related wellness issues, e.g. job burnout, dismissal, bullying and conflict.

A doctor's referral is not required, and the counselling team assesses whether follow-up interviews are needed.

You can call the hotline for stress and well-being every weekday between 9 am - 4 pm. You call via the main number at +45 7020 6121 and access the hotline via the menu.

6. What the insurance does not cover

Apart from what is stated in the insurance conditions, including the provisions of the individual covers, the insurance does not cover:

- Emergency treatment.
- Expenses for medical records, certificates, psychological and cognitive testing and similar.
- Expenses for doctors' referrals, doctors' recommendations, medical certificates and medical specialist certificates.
- Expenses for treatment outside normal working hours (weekend, evening or similar charges).
- Expenses for inserts, soles, mats, tapes, bandages and similar.
- Expenses for additional services such as shockwave, laser treatment, ultrasound and acupuncture.
- Expenses for aids.
- Scan and X-ray expenses (covered, however, in the event of a rapid examination).
- Transport and travel expenses.
- Treatments performed by you, family members, colleagues or a company belonging to one of these.
- Fees for failure to cancel or late cancellation for treatments. Costs due to your failure to attend treatment.
- Problems resulting from or during the performance of professional sports (sports activities where you are contractually paid by a sports club or sponsors, where the main income derives from the sport).
- Expenses for injuries caused intentionally or through gross negligence.
- Expenses for injuries caused by criminal offences.
- Experimental treatment. Examination/treatment that is not medically justified or has no proven effect.
- Treatment with Botox and Xiapex, Miradry or similar.
- Consultations and examinations by a general practitioner and specialist in general medicine.
- Diagnosing of chronic conditions, including chronic skin conditions, which arose before the insurance came into force. Examination of consequential conditions of chronic diseases is covered.
- Examination of cosmetic problems, including cosmetic skin disorders such as benign moles and blemishes, acne, eczema and all forms of warts, sun damage to the skin, actinic and seborrheic keratosis and skin disorders similar to these. Skin cancer (basal cell carcinoma) is covered until a diagnosis is made.
- Examination and treatment of hyperhidrosis.
- Examination of all kinds of dental problems.
- Examination and treatment of fertility and infertility. Scans and examinations during pregnancy and childbirth.
- Examination of sleep problems, sleep disorders, sleep apnoea and the like.
- Investigation in connection with impaired vision and impaired hearing, including squinting, binocular vision problems, need for glasses, contact lenses, sight tests, hearing aids and hearing tests.
- Diagnosing of anal fissure, anal fistulae, and pilonidal cysts.
- Investigation and treatment of phobias, such as dental phobia, fear of flying and exam anxiety. Social phobia.
- Behaviour modification treatment by a psychologist, such as problems with temper, infidelity, kleptomania, comfort eating and addiction. Couples therapy, family counselling, coaching, self-development, supportive and maintenance counselling and psychological treatments of a preventive nature are not covered.
- Examination by a psychiatrist.
- Examination by a neuropsychologist.
- Psychological help for serious mental disorders such as bipolar disorder, PTSD, psychosis, schizophrenia, eating disorders, OCD and the like.
- Psychological help for enduring disorders that require specialised treatment, such as ADHD, Tourette's syndrome, Autism Spectrum Disorder (ASD) and the like.
- Investigation for gambling addiction.
- Investigation of venereal diseases, sexual dysfunction, HIV/AIDS and their early stages and secondary complications.

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- Examination of discomforts, infection and other effects of implants, tattoos, piercings, prostheses and similar.
- Investigation, which we consider to be complicated and highly specialised.
- Investigations, screenings and examinations that are preventive.
- Investigation of cardiac conditions that we consider are best performed in the public health service.
- Examination and treatment of 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 and pandemics.

7. General provisions

Communication
We send letters and documents digitally. We use digital platforms such as e-Boks, the insurance company's user portal and mit.dk when we communicate with you about your insurance. We send invoices, notifications, premium increases and similar documents about your insurance via digital platforms. Receiving digital letters and documents has the same legal effect as receiving regular mail. This means that you must open and check what we digitally send to you. If you are exempt from digital mail such as e-Boks, you must notify us of this. We will then send your letters and documents by email or regular mail.

Communication regarding your reported claims is conducted with you either by telephone or via the correspondence function on the insurance company's user portal.

7.1 Duration of insurance
The duration of the insurance is stated in the insurance contract. The insurance will be automatically renewed on the renewal date unless otherwise stated in the insurance contract.

7.2 Insurance sum
The insurance sum is DKK 3,000,000 per person per year. The amount is fixed and is not adjusted. If an insured person uses up the insurance sum, no further expenses will be covered. The insurance sum applies as a total maximum, regardless of whether more covers and options have been purchased.

7.3 Payment of the premium
The premium is paid for the first time when it enters into force. Later payments will follow the contract. We will send an invoice to the notified e-mail address or by electronic invoicing. In other cases, we will send an invoice to the notified payment address. We should be notified immediately if the payment address is changed.

Monthly payment
In order to be able to pay the premium monthly, it is a requirement that the payment is registered with PBS or other direct debit payment methods.

Timely payment date
The amount is charged with information on the last timely payment date.

Overdue payment
If the amount in the first invoice is not paid on time, we have the right to terminate the insurance without further notice. We will send the first reminder letter if the amount in the subsequent invoices is not paid on time. If the amount is not paid within the deadline stated in the reminder letter, the policyholder loses the right to compensation. If the amount in the second reminder letter is not paid on time, the insurance will be cancelled.

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A fee is charged for every reminder letter sent. The fee is listed on our website www.ds-sundhed.dk. We also have the right to charge interest on the overdue amount in accordance with the Interest Act and the right to transfer the amount to legal debt collection.

Fee for services

We have the right to increase existing fees or introduce new fees to cover our costs fully or partially, e.g., in connection with:

- Sending of invoices.
- Provision of services related to the policy and processing of claims.
- Cancelling of the insurance before the end of an insurance period.
- Communication through non-digital channels.

We will increase an existing fee with one month's notice to the first of a month. We introduce new fees with three months' notice to the first of a month. We notify you of increases and new fees via our website. The fees are listed on our website www.ds-sundhed.dk.

7.4 Adjustment of premium and insurance conditions

The premium is adjusted once a year, unless otherwise agreed.

The premium is determined once a year on the renewal date. The price adjustment is based on the latest year's claims accounts and changes in the net price index.

Premium adjustment is not limited to changes in the net price index and/or legislative changes. If this happens, you can choose to terminate the agreement in writing at the latest during the month for it to come into effect at the end of the following month after the renewal premium notification has been received.

If the premium is based on some preconditions that are no longer present, we can adjust the premium on the next renewal date. If a risk account is prepared for the insurance, the premium will be adjusted according to special rules.

In addition to the index-adjustment, we can change the insurance conditions and/or the premium of already established schemes, with one month's notice to the end of a month, unless otherwise stated in the contract. The premium will be adjusted by a percentage determined by Dansk Sundhedssikring.

If you cannot accept the changes, you must terminate the agreement in writing within 14 days of receiving the notification of the notified changes. The insurance will then be terminated on the change date. If the agreement is not terminated in writing, the insurance will continue with the changed insurance conditions and/or price.

Changes to the insurance conditions that are exclusively of a clarifying nature and which do not impair the insurance coverage, e.g. linguistic updates and improvements, are not notified.

Premium changes due to index-adjustment and imposed taxes etc. by the public authorities are not regarded as a change to the insurance conditions or the price and will not be notified.

7.5 Cancellation and termination of the insurance

The insurance runs for one year at a time and is automatically renewed from the renewal date. The policyholder can cancel the insurance in writing with a notice of the current month plus one month. Cancellation at the renewal date is free. Cancellation beyond this date is subject to an administration fee.

Forsikringsselskabet Dansk Sundhedssikring A/S
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Dansk Sundhedssikring can cancel the insurance in writing during the month for it to come into effect at the end of the following month. In case of fraud or attempted fraud, we can terminate the insurance without notice.

The insurance ends at the end of the month if you no longer have a registered address in Denmark or if you fail to pay the premium.

Coverage on termination of the insurance

When the insurance stops, you lose the right to cover after 6 months for claims already reported and approved. Making of a new claim must always be done within 6 months of the end of the insurance period. The claim must always have occurred during the insurance period. If you have a referral from your own doctor, this must always be dated within the insurance period. Illnesses/disorders occurring after termination of the insurance or referrals dated after the termination of the insurance are not covered by the insurance.

The coverage requires that we have received all the necessary information.

Co-insured children who reach the age of 24 during the payment period are covered until the next payment period.
After the age of 24, according to our rules, you can apply to continue the insurance under our individual terms and at our individual p rices for privately insured adults. Your request for continuation must be made before or in direct connection with the end of the payment period. The continuation will then occur without a qualifying period for existing disorders.
If you do not request a continuation immediately, there will be a 6-month qualifying period for existing diseases in connection with a continuation.

Reimbursement of invoices after termination of the insurance

Invoices for approved treatments and/or transport must always be submitted no later than 6 months after the final treatment date in order to qualify for a refund.

7.6 Disclosure obligation

You are required to provide us with 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 should always be notified if you change addresses.

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 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's entry into force.

Membership of Sygeforsikringen ”danmark” must always be disclosed in connection with the creation of a claim, as we are entitled to receive this subsidy.

Double insurance

If changes are made to the insurance policy's risk condition, including double insurance, we must be immediately notified of this, as we may otherwise limit the cover or completely refuse to cover the claim.

If you have made a claim to another insurance policy, you must always inform us of this in connection with making a claim to us. If there is cover from another insurance company, the cover from this insurance will be secondary and the other cover should therefore be used first. We do not pay costs for claims for which cover has been received from another company.

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DANSK SUNDHEDS SIKRING

7.7 Processing of personal information

We treat your personal information confidentially and in accordance with applicable legislation. When you purchase insurance from us, we gather information in connection with enrolment, filing a claim and use of our digital platforms, e.g. Civil registration number, telephone number, e-mail address, industry, employment, marital status and any health information. This information is used to create and administer the insurance policy for use in case of a claim and in the ongoing case processing to ensure the best possible service and as part of sales management, product development, quality assurance, advice, and determination of general user behaviour.

We retain the gathered information for as long as necessary and in accordance with the applicable legislation. You can always contact us if you want to know which personal information we have registered about you. You are entitled to change incorrect information. On our website, www.ds-sundhed.dk, you can read more about data security and how we handle your personal information.

In some cases, we pass on personal information about you to the suppliers with whom we cooperate.

7.8 Processing of health information

There is no requirement to provide health information when you take out insurance with us. When reporting a disease/injury, you accept that we may obtain information about your health if we consider it to be relevant in connection with the reported disease/injury.

We can obtain the information from the public healthcare service, public authorities, including municipalities, the National Board of Industrial Injuries, insurance companies, pension companies, sundhed.dk, etc. Information is always obtained with your written or oral consent.
Health information is only used in connection with the handling of the reported disease/injury and is always handled in accordance with the requirements of the Health Act regarding confidentiality (Section 40 of the Health Act).

The disclosure of health information occurs solely in connection with the examination/treatment of the reported disease/injury in accordance with Section 41 of the Health Act regarding the disclosure of health information, etc. in connection with the treatment of patients.

7.9 Incorrect information

The insurance requires correct information. If you provide incorrect information or conceal information when the insurance policy is created or later, the right to cover may lapse in whole or in part.

7.10 Limitations

The agreement follows the normal rules of limitations under the applicable Limitations Act.

7.11 Avenues of complaint

If you disagree or are dissatisfied with our decision, please contact the department that has processed the case. If you are still not satisfied after contacting the department, please write to our quality department, which is responsible for complaints, in order to appeal your case.

Your complaint will be handled by a complaints manager as soon as possible and within no more than 7 working days.
You can send your complaint via the complaint portal on our website: www.ds-sundhed.dk.

The complaint must contain your name and address and a brief account of why you disagree or are dissatisfied with our decision. The complaint must be sent as soon as possible and no later than 6 months after the case has been settled.

DANSK SUNDHEDS SIKRING

If you then wish to appeal the decision taken by the complaints manager, you may appeal to the Insurance Complaint Board. You must send your complaint online at www.ankeforsikring.dk. There is a fee for appeals to the complaint board.

Applicable law

The insurance is subject to Danish law, including the Danish Insurance Contracts Act and the Danish Financial Business Act. Disputes about the insurance contract will be settled according to Danish law by the Danish courts and in accordance with the rules in the Administration of Justice Act regarding the legal venue.

We are not responsible for the results of examinations, treatments and assessments, including the lack of effect of treatment or if the treatment results in errors. Any claim for damages must be brought against the hospital or clinic responsible for the treatment.

In cases where a foreign-language insurance contract or insurance terms have been used, any discrepancies arising from the translation will mean that the Danish text is always applicable.

7.12 For further information

If you want to know more about your insurance, you can contact Dansk Sundhedssikring by telephone +45 70206121 or at the e-mail address: sundhedsforsikring@ds-sundhed.dk. You can also find more information on our website: www.ds-sundhed.dk.

7.13 Right of cancellation

For privately taken out insurance, a right of cancellation applies. This means that the policyholder may cancel a private agreement on insurance in accordance with the rules in Section 34 of the Danish Insurance Contracts Act.
According to the rules under the Danish Insurance Contracts Act, the policyholder is entitled to receive information on, e.g. the right of cancellation and the service ordered.

If you regret drawing a private insurance, you have a right of cancellation of 14 days. The right of cancellation is calculated from the date on which the agreement was entered into and where you have been informed of the insurance conditions, where the right of cancellation is also described.

If the right of cancellation period expires on a public holiday, Saturday, Constitution Day, Christmas Eve or New Year's Eve, the period does not expire until the following business day.

Before the right of cancellation period expires, you must notify us in writing that you have regretted entering into the agreement. You can let us know by letter or e-mail. The letter or e-mail must be sent before the expiration of the right of cancellation period. For cancellation during the cancellation period, please send a letter to:

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2730 Herlev

E-mail: sundhedsforsikring@ds-sundhed.dk