DANSK | SUNDHEDS SIKRING

Conditions

Health Insurance Flex

Occupational – full time

Version 3.0 | Forsikringsselskabet Dansk Sundhedssikring A/S | Q1 | 2025

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1. Contractual basis

These insurance conditions are valid from 1 January 2025.

The insurance has been taken out with Forsikringsselskabet Dansk Sundhedssikring A/S, CVR no. 34739307 – in the following referred to as "Dansk Sundhedssikring".

The overall insurance contract with Dansk Sundhedssikring A/S comprises the insurance contract (the policy), any supplements to the insurance contract and the insurance conditions attached to the insurance contract. The insurance is also subject to Danish legislation, including the Danish Insurance Contracts Act and the Danish Financial Business Act.

The insurance contract applies between Forsikringsselskabet Dansk Sundhedssikring A/S and the company, association or organisation listed as the policyholder in the policy.

The insurance conditions supplement the contract. Special provisions and any deviations from these insurance conditions must be stated in the insurance contract.

The policyholder is obliged to inform its employees/members about what the policy covers, which is stated in the insurance contract with any supplements.

Definitions used in the insurance conditions:

Company
Forsikringsselskabet Dansk Sundhedssikring A/S, referred to as "Dansk Sundhedssikring", "we" or "us" in the conditions.

Insurance period
The insurance period is the period from when the insurance takes effect until it ends, for whatever reason.

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

Insured
The person who is covered by the insurance, in the following often referred to as "you" or "your".

Musculoskeletal system
In these insurance conditions, musculoskeletal system refers to the large muscle groups and tendons in the back, neck, shoulders, elbows, wrists, hips, knees and ankles.

Chronic diseases/disorders/conditions
Chronic diseases/disorders/conditions are diseases, disorders and conditions that are considered by our doctors to be persistent and cannot be cured and do not go away with treatment, or where there is no curative treatment and/or where there is an ongoing or recurring need for treatment.

General physiotherapy
General physiotherapy (speciality 51), cf. the practice agreement for physiotherapy.

General chiropractic
General chiropractic (speciality 53), cf. the practice agreement for chiropractic.

Network
Our network of therapists in the form of a network of suppliers and therapists with whom we have entered into an agreement.

Physiotherapy free of charge
Scheme adopted under the Danish Finance Act that provides access to free (without charge) physiotherapy prescribed by a doctor for people with severe physical disabilities and physiotherapy for people without severe physical disabilities but with functional impairment as a result of progressive disease, cf. the Danish Health Authority's guidelines on access to free physiotherapy.

The Danish Health Authority
The highest health authority in Denmark.

The speciality plan
The speciality plan, issued by the Danish Health Authority in accordance with the Danish Health Act, with an overview of which hospitals and private hospitals are allowed to perform so-called speciality functions, such as performing certain operations and examinations.

1.1 When does the insurance apply?

The insurance applies in the insurance period. The insurance takes effect at the time agreed between the policyholder and Dansk Sundhedssikring.

1.2 What does the insurance cover?

We offer health insurance and health counselling with a wide range of in-house healthcare competencies and services in one single healthcare centre.

Healthcare professionals guide you to the right help, advice or treatment and are ready to help with all types of health problems – even those not covered by the insurance.

The healthcare team provides counselling and treatment based on the latest healthcare and evidence-based knowledge and experience, e.g. assessment of treatment needs, treatment methods, prevention and reduction of overtreatment.

The insurance covers examination and treatment of diseases, injuries and disorders that can, with a high degree of probability, be cured or significantly and permanently improved by treatment. We define diseases as health conditions, disorders or injuries that are symptomatic and which, in our judgement, result in a medically justified need for examination or treatment. We assess which examination or treatment is needed.

2. Who is covered by the insurance?

The insurance can be taken out by companies registered with a CVR no. in Denmark, and the companies must be located in Denmark, unless otherwise specified in the contract. The insurance covers the employees who are enrolled and named in the insurance contract. The insurance can be taken out for employees or a group of employees as a mandatory or voluntary scheme. There is no upper age limit for employees.

Insured persons must have a permanent registered address in Denmark (excluding Greenland and the Faroe Islands), be entitled to receive Danish public health insurance benefits and have a Danish health card, unless you are posted abroad.

2.1 Enrolment and withdrawal of employees

The company must always notify us on an ongoing basis of which employees it wishes to enrol or withdraw from the insurance scheme. Enrolment and withdrawal can only take place during the current annual period and a maximum of three months back in time. Adjustment in connection with the annual renewal, which triggers a new invoice, may be subject to an administration fee.

The company pays for claims payments that Dansk Sundhedssikring has made for employees who have been withdrawn back in time.

2.2 Co-insured children

It is possible to co-insure children at a separate price. Children that can be included are your biological and/or adopted children and your spouse's/partner's biological and/or adopted children who have an officially registered address with you. Your spouse's/partner's biological children and/or adopted children who do not have an officially registered address with you can be co-insured if your spouse/partner has taken out voluntary insurance. Children can be co-insured until the age of 24.

The insured must always notify us if there are any changes in the relationship that affect who should be covered by the insurance contract.

2.3 Waiting period provisions

For mandatory company schemes, there is no waiting period for pre-existing conditions. For co-insured and voluntary schemes, there is a six-month waiting period for pre-existing diseases and injuries. This means that you must have been covered by the insurance for six months before costs are covered for examination and treatment of conditions that have arisen and/or been diagnosed before the insurance took effect. Diseases and injuries that occur after the insurance takes effect are covered in accordance with the applicable insurance conditions.

Seniority from other health insurance can be transferred by direct transfer without delay from other health insurance.

The insurance offers health counselling and help for all types of health problems – also during the waiting period.

3. Where does the insurance cover?

The insurance covers examination and treatment in Denmark, and we refer you to a treatment centre in the public or private healthcare system.

The choice of treatment centre must always be agreed with us, and we may decide that the treatment must be carried out by a specific therapist or at a specific treatment centre. However, for some types of treatment, you are free to choose a therapist of your own choice. This will be stated in the individual cover.

Employees posted abroad and any co-insured children who are posted together with the employee are only covered for examination and treatment in Denmark, unless otherwise applicable to the agreement. Transport costs to and from Denmark are not covered.

4. Use of the insurance

The full conditions apply to all types of cover, but the detailed rules and exclusions are described in the individual cover. We therefore recommend that you read the full conditions before using the insurance.

4.1 Doctor's referral and documentation

Unless otherwise stated in the individual 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 any examination or treatment can begin. You should therefore start by consulting your GP, who can best assess your treatment needs. If your GP assesses that you need examination or treatment, you should, if possible, be referred for treatment in the public healthcare system. You can use this referral when you report the claim to us.

We can at any time ask you to submit medical records, referrals or certificates that we deem necessary for our medical assessment, including whether the reported condition is covered by the insurance.

For children under the age of two and pregnant women, we may, based on a medical assessment and in relevant cases, require that a doctor has assessed the need for treatment.

4.2 Examination and treatment must be approved

The insurance only covers expenses for examination and/or treatment that we have authorised in advance. It is therefore important that you do not initiate treatment without prior written authorisation. This also applies if there are changes to the treatment agreed with us.

The treatment centre must always be approved by us. If we have not approved the treatment centre, we may refuse cover.

4.3 Emergency treatment is not covered

Emergency treatment of somatic and mental conditions and acute situations are not covered by the insurance, including injuries/disorders that require assistance/examination/diagnostics and/or treatment earlier than the guarantee of ten working days and/or which cannot wait for planned treatment. This applies, for example, to traffic accidents, other accidents, concussion, fall traumas, bone fractures, blood clots/suspected blood clots, cerebral haemorrhage, heart disease, paralysis, acute sensory disturbances and other diagnostic areas that we and/or the public authorities define as acute, including cancer treatment packages, life-threatening cancer and ischaemic heart disease.

If you need emergency assistance, including an accident and emergency unit or ambulance, you must always contact your GP, the emergency medical service, the emergency telephone line, the accident and emergency unit or 112.

The insurance covers expenses for psychological treatment in the event of acute crisis counselling, cf. the provisions in section 5.6.1 "Acute crisis counselling".

4.4 Travelling and staying abroad

The insurance does not cover expenses for examination and treatment of disease/injury incurred while staying or staying abroad. Treatment will only be covered after your return to your permanent residence and based on the general conditions. This also applies if you are staying in Greenland or the Faroe Islands.

Travel expenses abroad are not covered, including private expenses such as hotel and companion expenses and companion stays, unless otherwise stated in the individual cover.

4.5 Absence from treatment

The insurance does not pay for no-show for examination/treatment, or fees for late cancellation.

4.6 Ongoing and planned treatment

Treatments and examinations that have been initiated or planned before the start of this insurance are not covered. If you have filed a claim with your previous insurance company, we will not cover the claim until after three months from the date you join our scheme. When we take over a claim from your previous insurer, it will be covered according to our current insurance conditions.

4.7 Expenses for treatments

All expenses must, in our judgement, be reasonable and necessary in relation to the expected result.

In our judgement, the treatments must be reasonable and necessary and expected to cure the conditions or significantly and permanently improve the state of health.

Treatments of a preventive, supportive, maintenance and palliative nature are not covered, unless otherwise stated in the individual cover.

The insurance covers your actual expenses for examination and treatment after deduction of reimbursement from the National Health Service. This means that in the event that the National Health Service covers part of the cost, we will offset that part and pay your share (co-payment). If you are a member of Sygeforsikringen "danmark", we will receive and set off the possible reimbursement for your treatment.

In cases where we refer you for treatment or examination at a private clinic or private hospital, payment will normally be made 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 the examination or treatment did not suit you, for whatever reason.

Physiotherapy, chiropractic, osteopathy and psychological treatment
For physiotherapy, the therapist's fee is covered, up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the indexed rates in the collective agreement.

Group exercise training with a physiotherapist is covered if it is part of a covered course of treatment and is approved by us. Group exercise training is covered corresponding to the full fee for group exercise training, which is indexed annually.

If you have a referral from your GP and the therapist works within the National Health Service, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to treatment in our network.

For chiropractic treatment, the amount corresponding to the patient share is covered according to the rate that applies to general chiropractic treatment (indexed annually).

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

Psychological therapy takes place digital/online in our quality-assured network, and we settle with the therapist.

The above provisions apply to the full insurance conditions, but the detailed rules and exclusions are stated in the individual covers.

4.8 Choice of therapist and treatment method

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

The insurance only covers the types of treatment mentioned in the insurance conditions under the various covers.

We can offer different types of treatment and counselling options, including digital services. The age limit for telephone and online treatment is 15 years.

For physiotherapy, chiropractic, psychological and psychotherapeutic treatment, we can offer treatment in our quality-assured nationwide network.

For children, treatment in the network can only be offered by therapists who offer treatment for children. However, you have the option to choose a therapist of your own choice. Psychological and psychotherapeutic treatment can only be offered in our network.

For osteopathy you can choose a therapist of your own choice. If you wish, the healthcare team can help you find a therapist.

For treatment in our network, we endeavour to start your treatment within four or five working days and a maximum of ten working days.

For assessment/xamination by a specialist, the first examination and/or treatment will be initiated within ten working days in the public or private healthcare system. We will refer you to a therapist/ treatment centre.

Treatment is covered only if it has been approved by the National Health Service in relation to the public healthcare system and authorised by the public health authorities in Denmark. The treatments must always be carried out using methods with documented effect and be included in the agreement with the National Health Service.

The treatment method must always be approved by us and be in accordance with the Danish Health Authority's speciality plan and the national clinical guidelines.

No cover is provided for alternative and/or experimental treatments that are not recognised for the treatment of the disease/disorder in question according to a general medical assessment, or that are not described in the national clinical guidelines and/or are frequently used and/or routinely performed in the public healthcare system.

The insurance does not cover expenses for consultation and/or treatment by general practitioners, psychiatrists, specialists in general medicine or equivalent foreign doctors, or experimental and alternative treatments/therapists, such as naturopaths, hypnotists and body therapists or other alternative therapists.

We do not cover expenses for examination or treatment performed by you, your family members or a company belonging to any of these.

4.9 Assessment of treatment needs

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 healthcare team of experienced nurses, doctors, physiotherapists and other healthcare professionals treat and assess all claims and complaints. The healthcare team determines whether the reported disease/injury is covered and assesses what examination or treatment is needed.

Only one form of treatment is covered at a time. If necessary, we may, based on a medical assessment, choose to cover several forms of treatment at the same time.

You are obliged to provide us with the information we deem necessary to make our decision, e.g. a doctor's referral or a copy of your medical records. As part of our assessment of whether a claim is covered or whether the expenses are reasonable, we may require a new assessment by a doctor appointed by us.

Based on a professional assessment, we can either refuse to cover treatment if the problem cannot be helped or stop a course of treatment if we assess that the treatment is ineffective.

4.10 Reporting a claim

The fastest way to report a claim is to report it online via our website: ds-sundhed.dk. Reported claims are processed quickly and in most cases overnight. Claims can also be made by phone.

If you have questions about your insurance or if your enquiry is about an existing case, you can contact the healthcare team via My DSS on our website: ds-sundhed.dk.

Emergency crisis counselling

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

5. What does the insurance cover?

This section contains the various types of covers.

The full insurance conditions apply to all sections, but there are special rules and exclusions that apply to each individual cover.

The various types of cover are described in the following sections:

5.1 Health Navigator and health counselling

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

You are offered telephone consultations with nurses, physiotherapists and doctors for all health and medical problems – even those that do not require actual treatment or are not covered by the insurance.

The health team can provide advice on health and well-being, welfare issues, stress and stress prevention, substance abuse issues, pain, pregnancy, concussion, menopause symptoms, diet, lifestyle changes, courses of treatment and management challenges and help with advice on relevant services for cancer patients, counselling groups, inspiration for mental exercises, dietary advice and exercise.

Our experienced nurses and physiotherapists can also provide advice on physical activity and sedentary time for adolescents, adults, elderly people and pregnant women, and how physical activity can relieve many symptoms, and provide access to materials, exercise guidance, exercise videos and an evidence-based exercise app.

We also offer various targeted counselling lines, which are described in more detail under the different covers:

- Pregnancy counselling
- Stress prevention and support helpline
- Abuse counselling
- Helpline for managers
- Online emergency medical service
- Personalised advice from trained pharmacists and pharmaconomists via chat, email or phone – including treatment options for menopausal discomfort, smoking cessation, medicines and dietary supplements, discounts on pharmacy products, and home delivery from a partner online pharmacy.

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

Through our unique Health Navigator and coordinator concept, we offer help in organising and carrying out the course of examinations and treatments as well as guidance on the public healthcare system's treatment options – e.g. patient rights, complaints procedures, compensation, guidance on waiting times, free choice of hospital and assessment and treatment guarantees. We also help you review medical records from hospitals and doctors, book appointments for treatment or examinations and guide about transport and other assistance if you need it.

In cases where the claim can only be resolved in the public sector or is not covered by the insurance, we offer counselling in connection with your course of treatment in the public healthcare system.

5.2 Pregnancy counselling

The health insurance offers telephone counselling for pregnant women and new parents with a personal pregnancy counsellor. Our pregnancy counsellors all have a relevant health professional background and offer telephone counselling on topics such as pregnancy problems, pregnant at work, the first post- partum period, parenting, abortion, diet, lifestyle, working life, childbirth, relationships, postpartum reactions, postpartum depression, maternity and breastfeeding and the child's well-being and development. Based on the dialogue with you, the pregnancy counsellor will assess whether a follow-up interview is needed.

You can call for counselling every weekday during the current opening hours, which can be found on our website. You call via the main number and access the helpline via the menu. If there is no available pregnancy counsellor, you will be called at an agreed time.

You can also contact the pregnancy counselling service using your computer, tablet or smartphone via the personal My DSS page. Here you can write when it suits you best and receive a written response or a call from a pregnancy counsellor at an agreed time.

5.3 Rapid assessment by a specialist

The insurance covers reasonable and necessary examination/assessment of a covered disease/injury performed by a relevant specialist at a hospital or clinic.

Reasonable examinations that we deem necessary to make a diagnosis are covered.

Relevant specialist examinations are covered until a diagnosis has been made, e.g. any imaging examinations or laboratory tests.

Doctor's referral
You must always have a valid referral or recommendation from your doctor. If your GP assesses that you need examination or treatment, you will be referred to a relevant specialist in the public healthcare system. You can use this referral when you want to use your insurance. Ultrasound scans, X-rays and MRI scans also require a referral.

Ten-day examination guarantee
You are guaranteed that a covered examination/assessment is initiated in the private or public healthcare system within ten working days after we have received and approved your claim.

If we need more information, such as a doctor's referral or other relevant information, the ten working days will start after we have received and approved the necessary information.

If you are already in a public programme or have been referred for examination/assessment in the public hospital system or with a public specialist and you are offered, or can be offered, a public appointment within the guaranteed ten working days, the public offer must always be activated and/or used.

If you are in an ongoing longer assessment programme in the public healthcare system and/or if we assess that the public healthcare system has the best options for examination/assessment, we may in relevant cases refuse cover in the private sector. We help with counselling and navigation in the further process.

If we assess that it is not possible for you to get an appointment within ten working days in the public healthcare system, including free choice of hospital and activation of the right to rapid assessment, and that examination/assessment in the private sector is the best solution from a healthcare perspective, we can instead refer you for examination at a private hospital or a private clinic in our network.

You must always use the therapist designated by us.

In cases where the waiting time in the private healthcare system is at the same level as in the public system, we may decide that the public offer should be used.

If the assessment leads to no diagnosis being made based on the symptoms of the disease, the assessment is concluded when the healthcare professionals consider that all relevant examinations have been completed.

The insurance does not cover further investigation of disease symptoms if we have previously covered assessment of the same condition/symptoms.

The subsequent course of treatment must take place in the public healthcare system.

Blockade treatment
In relevant cases, the insurance covers expenses for one therapeutic blockade treatment performed by a relevant medical specialist designated by us in cases where we make a medical assessment that blockade treatment can significantly and permanently reduce the condition.

Skin conditions
The insurance covers reasonable examinations of skin conditions performed by a medical specialist that we deem necessary to make a diagnosis.

The insurance covers assessment of skin conditions that we consider to have a significant impact on your health. Skin conditions and diseases that we consider to be cosmetic or chronic are not covered, cf. section 6 "What the insurance does not cover".

The insurance covers the removal of suspicious/malignant moles as part of the assessment process in relevant cases.

The subsequent course of treatment must take place under public auspices.

Recurring skin conditions or relapses, e.g. elsewhere on the body, are not covered.

We are always happy to provide counselling, navigation in the public system and appointment assistance for all skin conditions.

Skin cancer
The insurance covers the assessment of skin cancer (for example basal cell carcinoma and squamous cell cancer) until a diagnosis has been made.

The insurance does not cover the assessment of previously known skin cancer where there is an exacerbation, or in the event that the disease returns and requires a new examination.

Allergy testing
The insurance covers assessment of suspected allergies for the purpose of making a diagnosis. It is a condition for cover that your GP is not able to carry out the assessment in his or her practice. The assessment must be approved by us and prescribed by a relevant medical specialist.

The insurance does not cover cases where the GP has recommended or referred the patient for assessment at a public hospital.

The insurance does not cover assessment of previously known allergies or allergies that have worsened.

Cancer
The insurance covers assessment of cancer diseases. If the waiting time for assessment in the public healthcare system is at the same level as in the private system, the public service must always be used.

In case of cancer diseases that form part of a comprehensive treatment package in the public healthcare system, the public service must always be activated and used. The healthcare team helps with counselling in the further process.

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 ten working days, but the date does not suit you, for whatever reason.
- If you completely or partially reject an offer of examination in the private or public healthcare system, e.g. because you want a different treatment centre than the one indicated.
- If you express a wish for examination at a later date than during the period of the examination guarantee.
- If we assess that it is not medically appropriate to initiate an examination within 10 working days.
- If an authorised and scheduled examination or treatment is postponed for medical reasons.
- If you are undergoing an extended and/or long-term assessment programme in the public healthcare system.
- If we assess that the examination/treatment is highly specialised and should be performed in the public system, e.g. in the case of special disease diagnoses or complicated diseases, or if you are undergoing a long-term assessment process in the public sector.
- In the event of major conflicts and/or limited capacity in the public healthcare system, as well as unforeseeable events beyond our control, e.g. societal actions, IT crashes, hacker attacks, pandemics, epidemics, lockouts and similar – in these cases we are entitled to a reasonable extension of the guarantee.

5.4 Medical second opinion by our specialists

If you are facing a difficult decision or if there is uncertainty about your diagnosis or treatment, we offer telephone advisory consultations with our doctors and nurses. This also applies if two doctors disagree on your diagnosis or treatment (third opinion).

5.5 Physical health

From your first contact with the insurance company, the healthcare team can offer counselling and support to deal with physical challenges – whether they are covered by the insurance or not.

To ensure optimal prevention, counselling and treatment of your problem, we may, based on a professional assessment, refer you to various forms of counselling and treatment and/or self-training, e.g. exercise counselling, exercise videos, exercise apps, online physiotherapy, physiotherapy and chiropractic with physical attendance or a combination of digital treatment and physical attendance.

In cases where you are referred for treatment, the healthcare team will continuously assess how many treatments you need and whether you are receiving the right treatment.

Exercise app
Based on a health professional assessment, we can give you up to six months access to an exercise app that offers rehabilitation and prevention of pain throughout the body based on specially designed exercise programmes.

Get off to a good start – fast help for new and uncomplicated musculoskeletal pain in the musculoskeletal system
The healthcare team offers quick clarification of treatment needs, advice and guidance on exercises to manage your own pain, follow-up, care calls and access to an evidence-based training app based on the latest healthcare knowledge by experienced nurses and physiotherapists.

Physiotherapist, chiropractor and osteopath
The insurance covers reasonable and necessary treatment of new and existing musculoskeletal disorders and headaches due to musculoskeletal disorders following a referral from the healthcare team.

It is a prerequisite for cover that there is a medically documented need for treatment.

Our healthcare team of experienced nurses, doctors, physiotherapists, doctors and other healthcare professionals treat and assess all claims and complaints and determines what form of treatment is needed.

Only one form of treatment is covered at a time. If necessary, we may, based on a medical assessment, choose to cover several forms of treatment at the same time.

The insurance covers treatment by a physiotherapist, chiropractor or osteopath. Treatment in Denmark is covered.

You can choose which therapist to use. If you wish, the healthcare team can help you find a practitioner. For physiotherapy and chiropractic treatment, we can offer treatment in our quality-assured nationwide network.

Cover is provided for the number of reasonable and necessary treatments that are medically justified, up to a maximum of 12 physiotherapy or chiropractic treatments per calendar year with effect from the first day of treatment – also in the event of multiple injuries. Osteopathy is covered for up to five treatments per calendar year with effect from the first day of treatment – also in the event of multiple injuries.

In our judgement, the treatments must ensure progression and lead to a significant and lasting improvement of the condition.

Following a professional assessment, we may either refuse to cover treatment of a recurring condition/problem, or stop a course of treatment if the treatment is deemed to be ineffective.

Physical disorders that, in our judgement, cannot be cured or significantly and permanently improved are not covered.

You are obliged to provide us with the information we deem necessary to make our assessment of whether a claim is covered by the insurance and if the treatment is having the desired effect. As part of our assessment we can ask for a doctor's referral or a medical recommendation.

Reimbursement and subsidies
The insurance covers your actual expenses for examination and treatment after deduction of reimbursement from the National Health Service. This means that in the event that the National Health Service covers part of the cost, we will offset that part and pay your share (co-payment). If you are a member of Sygeforsikringen "danmark", we will receive and set off the possible reimbursement for your treatment.

For physiotherapy, the therapist's fee is covered, up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the indexed rates in the collective agreement. Group exercise training with a physiotherapist is covered if it is part of a covered course of treatment and is approved by us. Group exercise training is covered corresponding to the full fee for group exercise training, which is indexed annually.

If you have a referral from your GP and the therapist works within the National Health Service, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to treatment in our network.

For chiropractic treatment, the amount corresponding to the patient share is covered according to the rate that applies to general chiropractic treatment (indexed annually).

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

Online physiotherapy and blended care
In relevant cases, we can refer you to a targeted programme with a physiotherapist, with whom we have partnered. Based on a professional assessment and in consultation with you, the programme can be purely digital in the form of video consultations with the physiotherapist or a combination of digital treatment and physical attendance. The programme includes the option of a chat function between consultations and free access to a digital training platform.

The length of the programme depends on a professional assessment. You are offered a quick appointment with a quality-assured partner, and we settle directly with the therapist.

Treatment in Dansk Sundhedssikring's network
The insurance covers treatments with a physiotherapist or a chiropractor based on a professional assessment. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments.

You are offered a quick appointment with a quality-assured clinic, and we settle directly with the therapist.

Treatment outside Dansk Sundhedssikring's network
The insurance covers treatment by a physiotherapist, chiropractor or osteopath based on a professional assessment. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments. As part of our assessment, we may ask for a medical assessment or a written justification for continued treatment from the physiotherapist, chiropractor og osteopath.

You pay the therapist yourself. When your course of treatment is complete, you must submit a copy of all original bills. The bills must be submitted no later than three months after the last treatment in order for you to be eligible for reimbursement.

5.6. Mental health

Already at your first contact with the insurance company, the healthcare team can, based on a professional assessment, offer counselling and support to deal with mental challenges – regardless of whether they are covered by the insurance or not.

In cases where we assess that you need treatment for mental disorders or mental challenges – for example if you have a reduced ability to function in everyday life and/or symptoms that require treatment, cf. the provisions in section "Treatment with a psychologist and psychotherapist" and in section 1.2 "What does the insurance cover?" – the insurance covers reasonable and necessary treatment. It is a prerequisite for cover that the injury is eligible for cover.

We can offer telephone counselling for stress, wellbeing and life change challenges and refer you to online or telephone treatment with a psychologist or psychotherapist in our quality-assured network.

The type of programme will depend on the individual case and the professional judgement of the healthcare team. The details are set out in the individual sections.

In cases where our medical assessment is that assessment and/or treatment can best be carried out in the public sector, we can refer to public services to be activated and used. This may be the case, for example, in cases where there is no lasting improvement from previously attempted treatment with a psychologist and/or psychiatrist, or in the case of a recurring disorder or for assessment and treatment of suspected serious mental illness. We offer guidance and support in the process.

If you have been referred to a package programme in the public healthcare system, this offer must always be used.

Stress prevention and support helpline
When you have health insurance with Dansk Sundhedssikring, you can call for personalised and fast counselling and support for stress- or well-being-related problems that do not require actual treatment.

The stress prevention and support helpline is staffed by an experienced in-house counselling team, all of whom have relevant healthcare backgrounds and can help you prevent and deal with problems before they become serious.

Here you can get fast and personalised counselling and help to strengthen your mental health – already at the early signs of stress and well-being issues. Counselling is provided on for example:

- Reducing and preventing early signs of stress and unhappiness.
- Private well-being issues, such as personal crises, grief, children, relationships, divorce, lifestyle and substance abuse.
- Work-related well-being issues, such as burnout, dismissal, bullying and conflicts.

A doctor's referral is not required, and the counselling team will determine if follow-up counselling is needed.

As part of the stress and well-being line, we also offer:

- **Addiction counselling**
  Confidential conversations in the form of counselling and guidance on substance abuse problems by healthcare professionals. Counselling in provided on for example about addiction or treatment for different types of addiction (e.g. alcohol, cocaine, cannabis, drugs, compulsive gambling and compulsive buying) or about the challenges of being related to or close to someone with addiction problems. Substance abuse disorders of any kind are not covered by the basic insurance.

You can call the stress- and wellbeing helpline on weekdays during the current opening hours, which can be found on our website. You call via the main number and access the helpline via the menu. If there is no available counsellor, you will be called at an agreed time.

You can also contact the counselling service using your computer, tablet or smartphone via the personal My DSS page. Here you can write when it suits you best and receive a written response or a call from a counsellor at an agreed time.

Helpline for managers
The helpline for managers is an offer for HR and managers and provides access to telephone counselling where you as a manager can get help to explore new perspectives or explore your options for action if, for example, you have employees with stress, employees with personal challenges that affect their work, well-being issues, bullying, conflicts, or if an accident or violent incident has occurred in the workplace.

Through the helpline for managers, we can provide HR and managers access to relevant material on hormonal changes and working life, how to have an open dialogue and actively create the framework for a flexible and supportive work environment that accommodates menopausal employees, and we offer the opportunity to purchase external lectures and workshops with experts we collaborate with.

The helpline for managers is staffed by our internal mental health team, all of whom have relevant professional backgrounds. Based on the dialogue with you, the team will assess whether there is a need for follow-up sessions.

You can call the helpline for managers on weekdays during the current opening hours, which can be found on our website. You call via the main number and access the helpline via the menu. If there is no available counsellor, you will be called at an agreed time.

You can also contact the counselling service using your computer, tablet or smartphone via the personal My DSS page. Here you can write when it suits you best and receive a written response or a call from a counsellor at an agreed time.

Free access to mental health app and mindfulness for children, young people and parents
Based on a health professional assessment, we can give you six months' access to a mental health app. The app is based on cognitive behavioural therapy and teaches children aged 8 to 16 and their parents how to deal with difficult emotions and topics such as grief, bullying, shyness, divorce, social anxiety, sleep problems, gaming addiction and mindfulness for children and adults.

Digital ADHD/ADD counselling by a psychiatrist and specially trained psychologist
You get access to a digital learning platform with self-help in the form of useful knowledge and guidance on ADHD/ADD. The platform was developed by specialists in psychiatry and psychology and can also be used by carers. You must be 18 years or older to use the platform.

Digital treatment with a psychologist and psychotherapist
Based on a professional assessment of the need for treatment, the insurance covers relevant, reasonable and necessary individual treatment/therapy for mental disorders and mental challenges requiring treatment by an authorised psychologist (aut. cand.psych.) or a psychotherapist.

You are offered a quick appointment with a quality-assured psychologist or psychotherapist, and we settle directly with the therapist. Based on a professional assessment, we can refer you to online or telephone treatment. The age limit for telephone and online treatment is 15 years. The healthcare team provides counselling and support to deal with mental disorders for children under the age of 15.

The insurance covers the necessary number of treatments per disease/injury based on a professional assessment. We will assess whether you may need to submit a valid doctor's referral or a medical recommendation. Stress does not require a doctor's referral/recommendation. Based on a professional assessment, the team can refer you to various forms of stress prevention, counselling and treatment.

It is a prerequisite for cover that there is a medically documented need for treatment and that there are symptoms requiring treatment/impaired ability to function in everyday life.

In our judgement, the treatments must ensure progression and lead to a significant and lasting improvement of the condition.

Recurring disorders that have previously been treated via the insurance are not covered.

Mental disorders that, in our judgement, cannot be cured or significantly and permanently improved are not covered.

5.6.1 Emergency crisis counselling

The insurance covers emergency crisis counselling in our network if we assess that you have suffered an acute mental crisis due to the following:

- If you are exposed to a sudden, serious incident/accident where you are in danger.
- If you are the victim of robbery, assault, violence or kidnapping.
- If there is a fire, explosion or burglary in your private home or business (must be reported to the police).
- If you are diagnosed with a life-threatening disease.
- If there is a death in your immediate family.
- If a member of your immediate family is diagnosed with a life-threatening disease.
- If you witness the sudden, unexpected death or sudden serious incident/accident of a family member or colleague.

By immediate family we mean spouse, partner, own children, spouse's/partner's children and adopted children.

There is no requirement for a doctor's referral. The healthcare team assesses whether there is a need for emergency crisis counselling or referral to other treatment. If we assess that you need emergency crisis counselling, we will find a psychologist for you in our network. You will have telephone contact with the psychologist within three hours of the claim being accepted. The subsequent course of action will depend on the nature of the incident and the therapist's professional judgement.

If the claim is reported more than 48 hours after the crisis occurred, the cover for regular psychological counselling will always apply.

Emergency psychological treatment abroad is not covered.

Group debriefing is not covered unless it is part of the cover of an approved emergency programme.

5.7 Online emergency medical service

The insurance covers necessary medical consultations with a private emergency service doctor for the entire household, i.e. the insured, spouse/partner and the household's children under the age of 24 living at home.

Use of the service requires a Danish civil registration (CPR) number or a valid replacement CPR number, unless otherwise stated in the insurance contract.

The online emergency medical service is a supplement to your GP and offers quick access to email and video consultations with a private emergency service doctor outside of normal opening hours.

The medical emergency service is staffed by experienced specialists in general medicine and can provide medical advice and guidance and answer questions about illness and symptoms that do not require a physical examination. The emergency service doctor can also write and renew most prescriptions, provide advice on over-the-counter medicines and refer you to regional public hospitals.

For example, you can get help for otitis media, sinusitis, conjunctivitis, colds and flu, headaches and migraines, muscle and joint pain, asthma, allergies, ulcers, skin rashes and eczema, vomiting and diarrhoea, urinary tract infections, sleep problems, mental disorders, contraception, pregnancy and breastfeeding, and sick children with fever. In case of acute illness or acute exacerbation of an existing illness, you should immediately contact the emergency medical service or 112.

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

The emergency medical service can only refer you to a public hospital or emergency room in cases where it is deemed necessary based on a medical assessment. The emergency medical service cannot refer patients for imaging diagnostics. Transport in connection with hospitalisation is not covered. The emergency medical service can only arrange transport in the event of emergency hospitalisation via 112.

The emergency medical service does not issue prescriptions for addictive medicines or medicines with abuse potential, such as sleeping pills, tranquillisers or morphine drugs. Based on a professional judgement, the emergency medical service can always choose not to prescribe medication and instead refer patients to public treatment services.

The emergency medical service cannot issue medical certificates or doctor's notes in connection with driving licences, activities and health checks, as these require a physical examination.

The emergency medical service cannot answer questions about the health insurance, nor can it make private referrals/recommendations for specialist practices, 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 staffed by experienced doctors on weekdays, weekends and public holidays. It is quick and easy to use the medical service using a computer, tablet or smartphone. You can book an appointment at your convenience or wait for a doctor to become available. You can also write to the doctor 24 hours a day. During opening hours, you will receive a response within one hour. The emergency medical service can be used in Denmark and when travelling abroad.

When you use the emergency medical service, you are data-protected, and we do not have access to information about what you have discussed with the doctor.

You can read more about using the medical service on our website: ds-sundhed.dk.

6. What the insurance does not cover

In addition to what is mentioned in the insurance conditions, including the provisions of the individual covers, the insurance does not cover expenses for:

- Emergency treatment, cf. the provisions in section 4.3 "Emergency treatment is not covered". The insurance covers expenses for psychological treatment in the event of acute crisis counselling, cf. the provisions in section 5.6.1 "Acute crisis counselling".
- Preventive, supportive, maintenance and palliative examination and treatment, unless otherwise stated in the individual cover.
- Vaccinations, health examinations, health checks and other preventive check-ups.
- Assessment and treatment of asthma, leg length difference (anisomelia), scoliosis, hip dysplasia and dyspraxia.
- Assessment and treatment of anal fissure, anal fistula, pilonidal cysts and haemorrhoids.
- Assessment/examination and treatment of conditions that we consider cosmetic and their consequences, e.g. problems with cosmetic implants, drooping eyelids (lower and upper) and gynaecomastia.
- Treatment with Botox or Xiapex and the like. MiraDry and other treatments of sweating/hyperhidrosis.
- Examination of skin conditions that we do not consider to have a significant impact on health and/or that we consider to be cosmetic or chronic, such as benign moles and spots, lipomas, pigmentation changes, acne, eczema and eczema-like skin conditions, rashes and eczema/rash caused by allergies, hair loss, all types of warts, nail fungus, corns, psoriasis, vitiligo, rosacea, skin transplants, sun damage to the skin, actinic and seborrhoeic keratosis and similar skin conditions.
- Mohs surgery or similar types of treatment.
- Assessment and treatment of venereal diseases, HIV/AIDS and its precursors and sequelae. Contraception, including sterilisation, insertion and removal of IUDs for whatever reason and their consequences.
- Examination and assessment of sexual dysfunction.
- Assessment and treatment of infertility and fertility and its consequences. This also applies to psychological consequences.
- Examinations, check-ups, scan, birth preparation, private midwife and similar in connection with pregnancy and childbirth (here we refer you to the public services, and we provide counselling in the further process).
- Diseases of the unborn child. Colic pain and colic-like conditions in children, as well as growing pains and child incontinence.

- Treatment and assessment of ADHD, ADD and subtypes, ASD and all subtypes of autism spectrum disorders, dementia, Tourette's syndrome, eating disorders, OCD, anxiety attack and gender dysphoria.
- Treatment of severe mental illness, e.g. bipolar disorder, personality disorders, schizophrenia, psychoses, PTSD and diagnosed complicated grief. Treatment of diagnosed mental illnesses that fall under the public treatment packages.
- Consultations with a neuropsychologist.
- Assessment by and consultations with a psychiatrist. Medical expenses.
- Behavioural treatment by a psychologist, e.g. temperamental problems, infidelity, kleptomania, comfort eating and addiction (e.g. sex addition, porn addition and gambling addition).
- Couples therapy, parental and family counselling, family therapy, group therapy, coaching, self-development, personal development and similar, supportive and maintenance counselling and psychological treatments of a preventive and maintenance nature.
- Treatment of phobias, such as fear of flying, fear of heights, exam anxiety and social phobia and similar conditions. Treatment of OCD, OCD anxiety and its sequelae. Recurrent anxiety, that also applies recurring cases of panic disorder, anxiety attacks and generalised anxiety disorder.
- Medical records, certificates, psychological and cognitive tests, specialist medical certificates, doctor's referrals, doctor's recommendations not ordered by us, participation in meetings with municipalities, schools and others.
- Assessment and/or treatment programmes for mental disorders that we consider to be highly complex, e.g. assessment and treatment programmes that involve a complex clinical picture with several mental disorders and require special experience/competencies.
- If you have been referred to a public psychiatric package programme.
- Assessment of cardiovascular disease that we consider are best performed in the public healthcare system.
- Assessment of heart rhythm disorders.
- Assessment and treatment of sleep problems, snoring problems, sleep disorders, including sleep apnoea and snoring treatment. Treatment at a sleep clinic and the like.
- Dental problems.
- Assessment and treatment of discomfort/injuries to teeth, oral cavity and jaws.
- Sequelae of abuse of medication, alcohol, narcotics or other intoxicants.
- Diagnosed gambling addiction (compulsive gambling) and gambling addiction.
- Assessment/examination of all types of visual impairment and visual field symptoms, nearsightedness, farsightedness, astigmatism, binocular vision, co-vision problems, co-vision training, vision correction, dry eyes, floaters and eye spots, vitreous haze, strabismus, binocular vision problems, vitrectomy, vitreolysis and AMD.

- Glasses, contact lenses and/or vision testing, eye examination or other vision corrective treatments and aids.
- Assessment/examination of all types of hearing impairment symptoms, including general hearing examinations, hearing tests, hearing aids or other hearing-improving treatment.
- Treatments outside normal working hours, including weekend and evening supplements and the like, as well as additional services such as shockwave, laser treatment, ultrasound, acupuncture, massage, ultrasound scan and the like. Ultrasound scans are covered in relevant cases in accordance with the provisions of section 5.3 "Rapid assessment by a specialist".
- Pool training.
- Additional expenses for soles, inserts, bandages, tape, etc.
- Aids.
- Injuries arising from or during the performance of professional sports. Professional sport is defined as the practice of sport where you receive payment from a sports club or sponsors and where the sport is practised as your main occupation.
- Illness/injury caused directly or indirectly by self-inflicted intoxication, the influence of narcotics, laughing gas, solvents, medication or other intoxicants. Self-inflicted injury caused by intent or gross negligence, e.g. fights, suicide attempts, participation in criminal offences. Injuries caused by your failure to follow medical recommendations.
- Illness/injury, discomforts, infections and other consequences of implants, tattoos, piercings, prostheses, oil injections, anabolic steroids, doping and the like. Complications after treatment/surgery performed in the public or private healthcare system. Replacement of prostheses and implants that can be carried out in the public sector.
- Examination/treatment that is experimental and not medically justified or has proven efficacy.
- Growth factor and orthokine therapy, cryoneurolysis, PRF therapy, PRP therapy, HVI, hyaluronic acid (injections), Modic changes and other treatment that comparable to the above.
- Assessment and treatment of long-term and/or chronic pain problems at specialised clinics and pain treatment in connection with cancer. The healthcare team helps with counselling in the further process.
- Assessment and treatment at specialised clinics, such as Modic, headache, pain, sleep, cough or memory clinics and similar specialised clinics.
- Physiotherapy and chiropractic care for asthma and allergy disorders, insomnia, hypertension, cardiovascular disorders, Parkinson's disease, epilepsy, memory disorders, diagnosed headache disorders and jaw tension. The insurance covers professionally justified treatment of tension headaches caused by neck, shoulder and back tension.
- Physiotherapy for illness/injury/diagnosis where the treatment is covered under the free physiotherapy scheme.
- Private expenses, including hotel and companion expenses, private expenses during hospitalisation or similar.

- Transport and travel.
- Medication.
- Assessment of chronic diseases that occurred/became symptomatic before the insurance came into force. The insurance covers assessment of complications of chronic diseases.
- Assessment and treatment programmes and/or illnesses/injuries/disorders that we consider to be highly complex and highly specialised and which we consider to be best carried out in the public healthcare system, or complicated disease courses that require the presence of several interdisciplinary functions/specialists or require special surgical skills. For example, complicated reconstruction, amputation, transplantation, organ donation and transplantation, dialysis treatment, sex change operations, proton therapy and stem cell treatment.
- Injuries/diseases resulting from war or warlike acts and conditions, including civil war, civil unrest, rebellion, revolution, terrorism, bacteriological and chemical attacks, nuclear reactions, atomic energy, radioactive forces, radiation from radioactive fuel and waste and the like.
- Injuries/diseases resulting from general strikes, natural disasters, lack of electricity supply or network connections, epidemics, pandemics, viral infections and related vaccines. Consequential diseases caused by epidemics, pandemics and vaccines.

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 information about your insurance via digital platforms. When you receive digital letters and documents, they have the same legal effects as when you receive regular mail. This means that you must open and check what we send to you digitally. If you are exempt from digital mail, e.g. for having e-Boks, you must notify us. We will then send your letters and documents by email or regular mail.

Communication with you in connection with your reported claims takes place either by phone or via the claims function on the insurance company's user portal.

7.1 Duration of the insurance
The duration of the insurance is stated in the insurance contract. The insurance is automatically renewed on the annual renewal date.

7.2 Sum insured
The insurance covers reasonable and necessary customary expenses for illnesses, injuries and ailments based on the provisions of the individual covers.

7.3 Payment of the insurance

The insurance is paid for the first time when it comes into effect. Subsequent payments follow the contract. We will send an invoice to the e-mail address provided or via electronic payment collection. In other cases, we will send an invoice to the payment address provided. If the payment address is changed, we must be notified immediately.

Monthly payment
To be able to pay the insurance monthly, it is a requirement that the payment is registered for PBS or other automatic collection.

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

Late payment
If the amount in the first invoice is not paid on time, we have the right to terminate the insurance without further notice. If the amount in the subsequent invoices is not paid on time, we will send the first reminder letter. 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, we will cancel the insurance.

We charge a fee for each reminder letter we send. The fee can be found on our website: ds-sundhed.dk.

We also have the right to charge interest on the amount due in accordance with the Danish Interest Act and the right to assign the amount for legal debt recovery.

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

- Sending invoices
- Serving customers and performing other services in connection with policy and claims handling
- Cancelling the insurance before the expiry of an insurance period
- Communicating via a non-digital channel.

We 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 increases and new fees on our website: ds-sundhed.dk.

7.4 Premium adjustment and changes to insurance conditions

The price is adjusted once a year, unless otherwise agreed. An annual statement is prepared of the actual number of insureds versus the number paid for. Any difference is credited or debited to the policyholder.

The premium is set once a year on the annual renewal date. The premium adjustment is based on the last year's claims accounts and changes in the net price index or similar (Statistics Denmark).

The premium adjustment is not limited to changes in the net price index and/or statutory changes. If the premium is adjusted, you can choose to cancel the contract in writing with one month's notice after you received the notification of the renewal premium.

If the price is based on assumptions that no longer exist, we may adjust the price at the next annual renewal date. If risk accounts are prepared for the insurance, the price will be adjusted according to special rules.

In addition to the index adjustment, we can change the conditions and/or price for already established schemes with one month's notice to the end of a month. The price will be adjusted by a percentage set by Dansk Sundhedssikring.

If you cannot accept the changes, you must cancel the contract in writing within 14 days of receiving the notification of the notified changes. The insurance will then be cancelled on the date of the change.

If the contract is not cancelled in writing, the insurance will continue with the changed insurance conditions and/or price.

Changes to the insurance conditions that are solely of a clarifying nature and that do not impair the insurance cover, such as linguistic updates and improvements, are not notified.

Price changes as a result of indexation and taxes, etc. imposed by public authorities are not considered changes to the insurance conditions or the price and will not be notified.

7.5 Termination and cessation of the insurance

Insurance policies taken out for one year at a time are automatically renewed from the annual renewal date. Unless otherwise agreed, an annual policy is taken out with an annual statement of debit or credit.

The insurance can be cancelled in writing by the policyholder or Dansk Sundhedssikring with one month's notice to the expiry of the period. If the insurance is not cancelled, it will be renewed for one year at a time.

In the event of signs of fraud or attempted fraud, we can cancel the insurance without notice.

The insurance ceases at the end of the month in which your employment ends, if you leave the scheme, if you pass away, or in the event of non-payment of the premium.

The insurance ends at the end of a month if you no longer have a registered address in Denmark. This does not apply in the event of posting.

In any case, the insurance ends at the time when the overall agreement between the policyholder and Dansk Sundhedssikring ceases.

In the event of non-payment of the insurance premium, the rules under section 7.3 "Payment of the insurance" will be followed.

Cover on termination of the insurance
When the insurance ends, you lose the right to cover, and no new claims can be filed. Examination and treatment of disease/injury that has been reported and authorised during the insurance period is covered for up to three months after termination of the insurance. Cover requires that we have received all necessary information, e.g. a doctor's referral. This applies in all cases – even if the overall scheme ends.

Co-insured children
For co-insured children of a principal insured who are covered under a company scheme, the insurance will continue to the date for which cover has been paid, in cases where the principal insured leaves the scheme. Co-insured children who turn 24 during the payment period are covered until the next payment period.

Continuation of the insurance
If you are no longer covered by the company scheme, you can under our rules apply to continue your insurance on our individual conditions and at our individual price for private individuals. Your request for continuation must be made before or in direct connection with the withdrawal from the previous insurance contract. The insurance will then be continued without a waiting period for existing disorders. If you do not request continuation without delay, there will be a six-month waiting period for existing conditions. Co-insured children also have the option of applying for continuation of the insurance on our individual conditions and at our individual price for private individuals.

Reimbursement of bills after termination of the insurance
Bills for approved treatments and/or transport must always be submitted no later than three months after the last treatment date in order for you to be eligible for reimbursement.

7.6 Duty of disclosure

You are obliged to provide us with/send us the information we deem necessary to process the case so that we can assess the extent to which the insurance covers. If you move, we must always be notified.

We have the right to ask about your health, and you are obliged to provide us with all relevant information, including permission for us to obtain necessary information from doctors, hospitals and other professionals who have relevant knowledge of your health.

We may obtain the information we deem necessary, including obtaining medical records or other written material about your health.

We will only ever collect information with your consent. The information relates to both the period before and after the insurance takes effect. Membership of Sygeforsikringen "danmark" must always be stated in connection with the filing of a claim, as we are entitled to this subsidy.

Double insurance
If there are changes in the risk conditions of the insurance, including double insurance, we must be notified immediately, as we may otherwise limit the cover or refuse to cover the claim altogether. If you have reported the claim to another insurance company, you must always inform us of this when you report the claim to us. If another insurance company covers the claim, the cover from this insurance will be subsidiary and the other cover must therefore be used first. We will not pay expenses for claims for which full cover has been received from another company.

7.7 Processing of personal data

We treat your personal data confidentially and in accordance with applicable legislation. When you take out an insurance policy with us, we collect a range of information in connection with the registration, reporting of claims and use of our digital platforms, e.g. civil reg. no., telephone number, email address, membership of Sygeforsikringen "danmark", industry, employment, marital status and any health information. This information is used to create and administer the insurance policy for use when filing claims and in the ongoing case processing to ensure the best possible service and as part of sales management, product development, quality assurance, counselling and determination of general user behaviour.

We store the collected data for as long as necessary and in accordance with applicable legislation. You can always contact us if you want to know what personal data we have registered about you. You have the right to have incorrect information changed.

On our website, ds-sundhed.dk, you can read more about data security and how we process your personal data.

7.8 Processing of health information

There is no requirement to provide health information when you take out insurance with us. However, if you wish to join the scheme after having previously provided a waiver, we may require you to provide necessary health information. By reporting a disease/injury, you accept that we may obtain information about health conditions if we deem it relevant in connection with the reported disease/injury.

We can obtain this information from the healthcare system and public authorities, including municipalities, Labour Market Insurance, insurance companies, pension companies and sundhed.dk. The information is always obtained with your written or verbal consent.

Health information is only used in connection with the processing of a reported condition/injury and is always processed in accordance with the Danish Health Act's requirement for confidentiality (section 40 of the Health Act).

Disclosure of health information is only made in connection with the examination/treatment of the reported disorder/injury in accordance with section 41 of the Health Act on 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 withhold information – when the insurance is taken out or at a later date, the cover may be cancelled in whole or in part.

7.10 Time limitation

The agreement follows the normal rules of limitation according to the applicable Danish Limitation Act.

7.11 Avenues of complaint

If you disagree with or are dissatisfied with our decision, you should contact the department that handled the case. If you are still not satisfied after contacting the department, you can write to our complaints officer to have your case reassessed.

Your complaint will be handled by a complaints officer as soon as possible and within seven working days at the latest. You can submit your complaint via the complaints portal on our website: ds-sundhed.dk.

The complaint must include your name and address and a brief explanation of why you disagree or are dissatisfied with our decision. The complaint must be sent as soon as possible and no later than six months after the case was decided.

If you then wish to appeal the decision made by the complaints officer, you can appeal to the Insurance Appeals Board. The appeal can be submitted online at ankeforsikring.dk. Complaints to the Appeals Board involve a fee.

Governing law

The insurance is governed by Danish law, including the Danish Insurance Contracts Act and the Danish Insurance Business Act. Disputes about the insurance contract are settled according to Danish law by the Danish courts and according to the rules on venue set out in the Danish Administration of Justice Act.

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

In cases where a foreign-language insurance contract or foreign-language insurance conditions were used, any discrepancies resulting from the translation will mean that the Danish text will always apply.

7.12 If you want to know more

If you want to know more about your insurance, you can contact Dansk Sundhedssikring by phone or by email at sundhedsforsikring@ds-sundhed.dk.

You can find more information on our website, ds-sundhed.dk, where you can also report your claim online.