Topdanmark

DANSK SUNDHEDS SIKRING

Conditions

Serious illness

Occupational – full-time

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

Table of contents

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, the Danish Insurance Business 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:

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

Further
Further Underwriting International, S.L.U. – the company that provide the second opinion and concierge services.

Commencement date
The date cover starts as shown in the insurance contract.

Period of insurance
The period of insurance is the period from when the insurance commences 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".

Applicable period of cover
Period of 36 months, starting from the date of the first trip abroad organised and paid for by the insurance after a valid claim. A separate period of cover is established per cover module (applicable period of cover) when the first claim for the relevant cover module is approved and results in a trip for treatment abroad being organised and paid for by the insurance. The applicable period of cover is the period during which the insurance cover is paid for all approved claims under the same cover module.

Sum insured
The maximum amount payable, as defined in the insurance contract, in the event of a covered illness or treatment.

1.1 When does the insurance apply?

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

1.2 Medical definitions

Gene therapy products: Contains genes that have a therapeutic, prophylactic or diagnostic effect. They work by introducing 'recombinant' genes into the body – usually to treat a range of diseases, including genetic disorders, cancer and long-term illness. A recombinant gene is a strand of DNA or RNA created in a laboratory using DNA or RNA from different sources.

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

Tissue-engineered products: Contains cells or tissues that have been modified so they can be used to repair, regenerate or replace human tissue.

Alternative therapies and medicine: therapies, practices and medicines that are not considered part of conventional medicine or standard treatment in this insurance, including acupuncture, aromatherapy, chiropractic care, homeopathy, naturopathy, ayurveda, traditional Chinese medicine and osteopathy.

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

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

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

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

Disease/disorder: Any illness or disorder of the body, system or organ structure with identifiable and characteristic signs and symptoms or consistent anatomical changes and for which there is a diagnosis by a licensed physician. A disease/disorder is considered to be any injury and impact arising from the same diagnosis, as well as any disorder arising from the same or a related cause. If a disorder is due to the same cause that produced a previous disease or a related cause, the disease is considered a continuation of the previous disease and not a separate disease.

Medically necessary: Healthcare services or treatments to which the insured is referred in connection with a covered illness or the performance of a covered procedure that are intended to improve the insured's health and are recognised as effective in improving the health outcome according to treatment plans that are consistent in type, frequency and duration with the diagnosis according to medical literature. Such health care services or treatments must be cost-effective compared to alternative treatments that produce similar outcomes – including no treatment – and are necessary for reasons other than the convenience of the insured or his/her physician. The fact that a physician recommends, prescribes, directs or authorises a health care service or treatment does not necessarily establish that the service or treatment is medically necessary for the purposes of this insurance.

Preliminary medical certificate: Written approval, issued by Further and/or the insurance company, which under this insurance includes confirmation of cover for any treatment, service, benefit or prescription prior to treatment abroad carried out at the specified hospital.

Pre-existing disease: Any disease or medical condition of the insured, which was reported, diagnosed, treated, or which showed related medically documented symptoms or signs within five years prior to the commencement date of the insurance (or the relevant inclusion date of the insured).

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

Reconstructive surgery: Procedures or surgery intended to reconstruct a structure after loss of function.

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.

- **Compulsory group insurance**

A compulsory group insurance is taken out by an employer or an organisation for its employees or members, whereby each employee/member og the group becomes included directly by virtue of the group agreement.

Eligibility rules for employees/members under compulsory group insurance:

1. The insurance can be taken out for employees/members aged 18-66.
2. For employees/members over the age of 66, specific authorisation from the insurance company is required.

- **Voluntary group insurance**

A voluntary group insurance is taken out based on a voluntary application from persons in a voluntary group defined by the enterprise or by these individuals not declining the insurance.

Eligibility rules for employees/members under voluntary group insurance:

1. The insurance can be taken out for employees/members aged 18-66.
2. The employee/member can be insured under the group agreement until the earliest of the following:
   - Retirement age or membership end date
   - The annual policy anniversary after the employee's/member's 85th birthday.

The insured must:

1. have a permanent registered address in Denmark (excluding Greenland and the Faroe Islands)
2. have a Danish health insurance card
3. be entitled to receive Danish public health insurance benefits

or be resident in Norway, Sweden or Germany and be entitled to receive benefits equivalent to the public health insurance benefits through public or private cover in their country of residence.

All benefits during treatment abroad are covered outside Denmark and the country of residence (if the employee is residing in Norway, Sweden or Germany). After completed treatment abroad, medication and follow-up care services are only covered in the country of residence, unless medication and/or follow-up care is not available in the country of residence, see section 6.5.1 and section 6.5.2.

Exclusions will be stated in the contract.

2.1 Enrolling and disenrolling employees

The company must always keep us informed of which employees should be enrolled in or disenrolled from the insurance plan. Enrolment and disenrolment can only take place during the current annual period and no more than one month back in time. Adjustment in connection with the annual renewal, which triggers a new invoice, may be subject to an administration fee. The enterprise pays for claims payments that Dansk Sundhedssikring has made for employees who have been disenrolled back in time.

2.2 Co-insured

It is possible to co-insure your spouse/partner/children at a separate price. Children who can be enrolled are your biological children 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. Your spouse/cohabiting partner and your children can also be enrolled in a compulsory or voluntary scheme.

Children

Children can be co-insured via the compulsory or voluntary group insurance if they are a maximum of 26 years old at the time of enrolment and can be covered until the age of 27.

Cover ceases at the earliest of the following:

- The termination of cover for the employee for any reason, including resignation, termination of employment, retirement, end of membership or change of residence.
- The annual policy anniversary after the child's 27th birthday.

Spouse/partner

Your spouse/partner can be co-insured via the compulsory or voluntary group insurance provided that your spouse/partner is a maximum of 64 years old at the time of enrolment, and can be covered until the age of 85.

Cover ceases at the earliest of the following:

- The termination of cover for the employee for any reason, including resignation, termination of employment, retirement, end of membership or change of residence.
- The annual policy anniversary after the spouse's/partner's 85th birthday.

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

3. Cover modules

The insurance covers examination and treatment of covered illnesses with the aim of improving the insured's state of health. We assess which examination or treatment is necessary.

The purpose of this insurance is to provide the insured with cover for services and medical expenses in connection with the treatment of covered illnesses and covered medical procedures as described in this section 3.

Services:
Second opinion: A second opinion (the opinion of a doctor other than the patient's current doctor) will be given in accordance with the applicable terms of cover. This is done by providing a second opinion report prepared on the basis of a specialist doctor's obtaining and detailed review of the patient's medical records and medical history.

When filing a claim, the insured is entitled to request a second opinion from Further to confirm the diagnosis of the covered illness or treatment and to assess the optimal treatment plan.

Only one second opinion can be requested per claim.

Medical concierge service: If the claim is approved, a medical concierge service will arrange all details relating to the insured's medical treatment. This includes a comprehensive overview of the case and assistance with travel and accommodation arrangements for the insured and any companion.

Covered illnesses:

3.1. Cover module 1: Cancer treatment

The insurance covers treatment of the following types of cancer:

1. Any malignant tumour, including leukaemia, sarcoma and lymphoma, characterised by uncontrollable growth and spread of malignant cells and tissue invasion.
2. Any in situ (precancerous) cancer that is confined to the epithelium of origin and which does not invade the stroma or surrounding tissue.
3. Any precancerous cell change that is cytologically or histologically classified as moderate or severe dysplasia (moderate or severe change).

Note: The following illnesses are not covered:

- Treatment of tumours co-existing with AIDS.
- Treatment of non-melanoma skin cancer that is not histologically classified as causing invasion beyond the epidermis (outer skin layer).
- Treatment that includes CAR-T cell therapy.

Covered treatments:
The following treatments are covered by the insurance if the underlying disease that is the reason for treatment is not related to cancer treatment:

3.2 Cover module 2: Cardiovascular treatment

Coronary artery bypass surgery (myocardial revascularisation)

Surgical procedure recommended by a consulting cardiologist to remove narrowing or blockage of one or more coronary arteries by bypass graft.

Note: Treatment of the following diseases is not covered:

- Coronary artery disease treated by means other than coronary artery bypass grafting, such as angioplasty or stenting.

Implantation or repair of a heart valve

Invasive implantation or repair of one or more heart valves, whether by open heart surgery, minimally invasive heart surgery or by cardiological catheterisation on the recommendation of a consulting cardiologist.

3.3 Cover module 3: Neurosurgery

Intracranial and specific spinal surgery

- Surgical intervention in the brain or other intracranial structure.
- Treatment of benign tumours in the spinal cord (medulla spinalis).

3.4 Cover module 4: Transplantation

Organ transplantation from a living donor

Invasive implantation or repair of one or more heart valves, whether by open heart surgery, minimally invasive heart surgery or by cardiological catheterisation on the recommendation of a consulting cardiologist.

Note: Treatment of the following diseases is not covered:

- Transplantation where the need has arisen as a result of alcoholic liver disease.
- Transplantation performed as self-transplantation.
- Transplantation where the insured is a donor for a third party (not covered by the insurance).
- Transplantation from a deceased donor.
- Organ transplantation that includes stem cell treatment.
- Transplantation made possible by the purchase of donor organs.

Bone marrow transplantation

Bone marrow transplantation (BMT) or peripheral blood stem cell transplantation (PBSCT) from bone marrow cells to the insured originating from the insured (autologous bone marrow transplant) or from a living compatible donor (allogeneic bone marrow transplant).

Please note that haematopoietic stem cell transplantation (HCT) using umbilical cord blood is excluded.

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.

The insurance provides cover to the insured when the following conditions are met:

4.1 Period of cover

The medical services, procedures and treatments must be performed during the applicable period of cover. The applicable period of cover lasts up to 36 months and begins on the date of the first trip to receive treatment abroad.

4.2 The disease must not be a pre-existing disease

The disease must have occurred during the period of insurance. Diseases that occurred and/or were diagnosed up to five years before the insurance came into force are not covered. This also applies to related symptoms or signs of illness that are medically documented during the same five-year period.

4.3 Medically necessary treatment

The treatment must, in our judgement, be medically necessary and expected to cure the condition or permanently improve the condition. Treatments of a preventive nature are not covered. A medical treatment or service is considered medically necessary when:

- The insured is referred for treatment of a covered illness or the performance of a covered procedure that is intended to improve the insured's medical condition.
- It is recognised as suitable to improve the health outcome according to treatment plans that are consistent in type, frequency and duration with the diagnosis according to medical literature (e.g. PubMed) or scientifically based guidelines in the USA, UK or Europe (in particular the NCCN Clinical Practice Guidelines in Oncology are used for cancer treatment (cover module 1)).
- It is cost-effective compared to alternative treatments that produce similar results – including no treatment.
- It is necessary for reasons other than the convenience of the insured or his/her physician.

The fact that a physician recommends, prescribes, directs or authorises a health care service or treatment or aid/equipment does not necessarily in itself determine that the relevant service is medically necessary under the insurance conditions. The treatment and method of treatment is only covered by the insurance if it has been authorised by us.

4.4 Expenses

All expenses must be within the sum insured and the limitations stated in the individual conditions. All expenses must, in our judgement, be reasonable and necessary in relation to the expected result. We will refer you to a clinic or private hospital abroad, and payment is made directly between the treatment centre abroad and us.

4.5 Treatment is arranged by Further

Treatment is arranged by Further in accordance with the claims procedure described in clause 5.

4.6 Medical expenses

Treatment costs incurred outside the country of residence (and in Denmark for employees residing outside Denmark) are covered, with the exception of:

- Medical expenses covered under section 6.5.1
- Expenses for follow-up care covered under section 6.5.2.

Expenses for diagnosis, treatment, services, aids/equipment or prescriptions are covered by the insurance as stated in section 6.

4.7 Examination and treatment must be approved

We must always authorise all examinations and treatment before they begin. It is therefore important that you do not initiate treatment without prior written authorisation (and medical certificate), as we may otherwise reject the cover. This also applies if there are changes to the treatment agreed with us.

4.8 Travelling and staying abroad

The insurance does not cover expenses for examination and treatment of illness/injury incurred while travelling or during stays abroad that are not related to the covered illness or covered medical treatment. See section 6.2 (5) regarding complications and side effects.

4.9 Absence from treatment

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

4.10 Ongoing and planned treatment

Treatments that have been initiated or planned before the start of this insurance are not covered. Please see section 7 for clarification of cover for pre-existing conditions.

5. Claims procedure

Before treatment, service or prescription can be received in relation to the covered illness or treatment, cf. section 3, the insured or the person legally acting on his/her behalf must comply with the following:

5.1 Reporting a claim

Claims must always be reported during the period of insurance. Claims can be reported by telephone to Dansk Sundhedssikring on +45 70206121.

If you have any questions about your insurance or if your enquiry is about an existing case, you can contact the healthcare team by telephone on +45 70206121 or via the email address sundhedsforsikring@ds-sundhed.dk.

If your enquiry is about an existing case, you can contact Further at the email address claims@wegofurther.com.

5.2 Assessment of cover

The insured will be informed about what Further requires in terms of diagnostic tests and documents in order to assess whether the claim can be covered by the insurance.

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.

In the event that the insured requests a second opinion (see section 6.1), such second opinion must be given before further assessment of the claim can be made.

5.3 The insured's obligations

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.

The insured is obliged to cooperate with Further and provide all medical documents that may be available from the insured, doctors, hospitals or other treatment centres that have been responsible for the treatment up to the date on which the claim is reported.

Claims will only be assessed for eligibility for cover under the insurance once all necessary information has been received from the insured and the respective doctors, hospitals or other treatment centres.

5.4 Claims assessment and offer of hospital treatment

When Further has received all relevant diagnostic tests and medical history as requested, the insured will be informed whether the claim is eligible for cover under the insurance conditions.

If the insured wishes to consider treatment abroad, the insured will be provided with a list of recommended hospitals.

In this connection, Further will assess the possibility during the applicable period of cover, which gives the following scenarios:

- **Scenario 1 – full cover:**
  No claim has previously been reported under the relevant cover module that has resulted in an agreement on and payment for treatment covered by the insurance. Further thus confirms full cover for 36 months during the applicable period of cover.

- **Scenario 2 – partial cover:**
  Claim(s) have previously been reported under the relevant cover module that has resulted in an agreement on and payment for treatment covered by the insurance. Further thus confirms cover for the remaining months of the applicable period of cover.

- **Scenario 3 - the applicable period of cover has expired:**
  Claim(s) have previously been reported under the relevant cover module that has resulted in an agreement on and payment for treatment covered by the insurance that has run until the end of the applicable period of cover. Further thus confirms that the claim is not eligible for cover under the insurance.

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

5.5 Treatment abroad: preliminary medical certificate

Upon receipt of the insured's confirmation of the decision to receive treatment abroad at one of the treatment hospitals recommended in the list, and provided that the treatment is scheduled to begin before the expiry of the applicable period of cover, Further will through the medical concierge service make the necessary practical and medical arrangements for the proper hospitalisation of the insured and a preliminary medical certificate will be issued, which will only be valid for the hospital in question.

The medical concierge service is a service where – in connection with an authorised claim – Further arranges all details regarding the medical treatment of the insured. This includes case overview as well as making travel and accommodation arrangements for the insured and an approved companion.

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

If the insured does not choose a hospital from the list of recommended hospitals or does not start treatment at the authorised hospital listed in the preliminary medical certificate within three months of the date of issue, new versions of these documents may be issued based on the insured's state of health at that time.

As long as the terms of the preliminary medical certificate are fulfilled, the insurance company will, in accordance with the insurance cover herein, assume the treatment expenses covered under travel and accommodation expenses – subject to the limitations, exclusions and conditions stated in the insurance.

5.6 Applicable period of cover

The applicable period of cover lasts up to 36 months and begins on the date of the first trip to receive treatment abroad.

The insurance covers services and expenses (up to the limits stated in the conditions) incurred in connection with a valid claim under the insurance during the period of cover.

If the insured is hospitalised or receiving treatment in a hospital under the terms of the preliminary medical certificate at the end of the applicable period of cover, the insurance will continue to cover the treatment expenses stated in section 6.1 until the next scheduled return to the country of residence, which will be stated in the established treatment plan.

5.7 Return from treatment abroad

If the final return to the country of residence occurs before the applicable period of cover expires, Further will provide the insured with the guidelines for cover of treatment expenses after the return from treatment abroad, as stated in section 6.5. The guidelines will be based on the recommendations of the foreign doctor(s).

The insured will then be entitled to:

- Cover of medical expenses as stated in section 6.5.1
- Cover of expenses for follow-up care, as stated in section 6.5.2, until the end of the applicable period of cover.

5.8 Claims assessment after returning from treatment abroad

After the treatment plan has been finalised and after the final return to the country of residence, the insured's state of health may determine whether an assessment of further treatment needs must be made. This is on the condition that the insurance is still active within the applicable period of cover. The insured is entitled to contact Further for such an assessment.

Further will then inform the insured whether there is a need for the insured to provide and disclose information about diagnostic examinations, medical records and the like in order for such an assessment to be made.

If Further assesses that there is a medical need for further treatment, this will be confirmed to the insured by issuing a new preliminary medical certificate, including a list of recommended hospitals and possible treatments abroad, cf. section 5.4 and section 5.5.

If Further finds it medically justified, a new second opinion may be required.

The insurance will continue to provide cover for all services and expenses for treatment as stated in section 6.2 until the end of the applicable period of cover according to the terms of the latest preliminary medical certificate.

5.9 Co-operation

The insured and his/her family must authorise visits by doctors working for Further and/or the insurance company, and any enquiries by the doctor that the insurance company considers necessary in connection with his/her visits and treatment of the insured will be exempt from confidentiality.

Failure to authorise these visits will be considered by the insurance company as a waiver of the right to cover for the claim in question under the insurance.

6. What does the insurance cover?

The insurance provides financial cover and covers services and expenses (up to the limits stated in the conditions) incurred in connection with an authorised claim under the insurance.

The services must be organised, and the expenses incurred, during the applicable period of cover. The various types of cover are described in the following sections:

6.1 Covered services before travelling abroad for treatment

When filing a claim, the insured is entitled to request a second opinion from Further to confirm the diagnosis of the covered illness or treatment and to assess the optimal treatment plan.

This includes the provision of a second opinion report prepared on the basis of obtaining and detailed review of the insured's medical records and medical history. This is carried out by a medical specialist.

Only one second opinion can be requested per claim. If the insured requests a second opinion, this service must be performed before a final confirmation of cover for the claim can be made.

6.2 Covered treatment costs during treatment abroad

The preliminary medical certificate is a written authorisation issued by Further, which contains a confirmation of the cover, cf. the insurance contract, before treatment abroad can be performed at the designated hospital. The preliminary medical certificate will contain information about which treatments, services or prescriptions are covered in connection with the claim.

The insurance pays the following treatment expenses for treatment abroad (up to the limits stated in the conditions) if they arise in connection with the medically necessary treatment of covered illnesses and treatments in accordance with the conditions stated in the preliminary medical certificate:

1. In a hospital:
   - Accommodation, meals and general care provided during the insured's stay in a ward or department of the hospital or in an intensive care or monitoring unit
   - Other hospital services, including those provided by the hospital's outpatient departments (including interpreter services) and extra bed space if the hospital provides this service
   - Use of an operating theatre and related services.

2. In a clinic or independent health centre – but only if the treatment, surgery or prescription would be covered by the insurance if the service was provided by a hospital.

3. Doctor in connection with examination, treatment or surgery.

4. Doctor's visit during hospitalisation.

5. Services, treatments and prescriptions:
   - Anaesthesia and management of anaesthesia if performed by a certified anaesthesiologist.
   - Laboratory analysis, pathology and X-rays for treatment purposes, radiotherapy, radioactive isotopes, chemotherapy, ECG, ECG, myelogram, EEG, angiogram, CT scan and similar tests and treatments necessary in the treatment of the covered illness, if performed by a physician or under medical supervision.
   - Blood transfusion, receipt of plasma or serum.
   - Use of oxygen, intravenous solutions and injections.
   - Radiotherapy: High-energy rays that shrink tumours and kill cancer cells using X-rays, gamma rays and charged particles are forms of radiation used in cancer treatment – either using a device outside the body (external beam therapy) or by placing radioactive material in the body near the cancer cells (internal beam therapy, brachytherapy).
   - Reconstructive surgery to repair or rebuild a structure that has been damaged or removed by the treatments arranged and paid for by the insurance.
   - Complications and side effects directly related to the treatment arranged and paid for by the insurance and which:
     1. Require immediate treatment in a hospital or clinic
     2. Require treatment before the insured is declared medically fit to return to the country of residence after treatment abroad.

6. Medication used after being prescribed while the insured is hospitalised for treatment of a covered illness or examination. Medication prescribed for post-operative treatment is covered for 30 days from the date the insured completed the treatment abroad and only if purchased before returning to the country of residence.

7. Ambulance transport by land or air if the use is specified and prescribed by a doctor and pre-approved by Further.

8. Services to a living donor during the process of removing an organ to be transplanted into the insured:

   - Analysis and tests performed to find a suitable donor within the insured's family.
   - Hospital services, including hospitalisation in a hospital ward or department, meals, general care, general services provided by hospital staff, laboratory tests and use of equipment and other hospital facilities (excluding items for personal use that are not required in the process of removing the organ or tissue to be transplanted).
   - Surgery and treatment for the removal of the donor organ or tissue for transplantation into the insured.

9. Services and materials in connection with bone marrow cultures for tissue transplant to the insured. Cover is only provided for expenses incurred from and including the date of issue of the preliminary medical certificate.

6.2.1 Force majeure

If force majeure or logistical or operational restrictions imposed by local or international authorities prevent Further from organising treatment abroad, Further will arrange for the services set out in section 6.2 "Covered treatment expenses during treatment abroad" to be provided in the country of residence, provided that the same logistical or operational restrictions do not prevent the organisation of an equivalent and medically sound alternative in the country of residence.

Services listed in section 6.2 are only available in the country of residence until Further is able to confirm the re-establishment of organised treatment abroad. The services arranged and established by Further and provided in the country of residence are covered in addition to any cover by the public healthcare system in the country of residence or other insurance with Dansk Sundhedssikring.

6.3 Covered non-treatment-related expenses during treatment abroad

The insurance covers the following non-treatment-related expenses (up to the limit stated in the conditions) incurred in connection with travel and stay organised by Further to give the insured access to treatment in accordance with the conditions stated in the preliminary medical certificate.

Organised travel and stay is covered for the insured and one travelling companion (possibly two travelling companions if the insured to be treated is a minor), where each trip includes the journey from the country of residence to the treatment destination and back and the necessary accommodation during each trip.

The dates and duration of the trip will be determined by Further on the basis of the treatment plan indicated by the attending physician(s).

Travel and accommodation for each covered trip is covered in accordance with the terms and conditions set out below:

Travel expenses for treatment abroad
For trips outside the insured's country of residence, travel expenses are covered for the insured and one travelling companion (possibly two travelling companions if the insured to be treated is a minor) and possibly the living donor for transplantation for the sole purpose of receiving treatment abroad as approved by Further/the insurance company in the preliminary medical certificate. All travel arrangements must be made by Further and the insurance company will not pay for trips organised by the insured or by a third party on behalf of the insured.

Further is responsible for setting the travel dates for each covered trip on the basis of the approved treatment plan. The insured will be notified of these dates in good time to enable the insured to make the necessary personal arrangements.

If the insured changes the travel dates from those notified by Further/the insurance company, the insured must compensate the insurance company and/or Further for the expenses associated with organising and notifying new travel arrangements, unless the changes are confirmed by Further to be necessary from a health point of view.

Covered travel expenses include:

- Transport from the insured's permanent residence to the designated airport or international train station
- Economy class train or flight ticket to the treatment city and transport to the designated hotel
- Transport from the designated hotel or hospital to the designated airport or international train station
- Economy class train or flight ticket and subsequent transport to the insured's permanent residence.

The covered travel expenses do not include general transport between hotel and hospital or attending physician during treatment abroad.

Covered accommodation expenses for treatment abroad
Expenses are covered for stays outside the country of residence for the insured, the travelling companion (or the two companions if the insured is a minor) and the living donor for transplantation for the sole purpose of receiving treatment abroad that has been approved by Further/the insurance company in the preliminary medical certificate. All accommodation in connection with each trip covered by the insurance must be agreed with Further, and Further/the insurance company will not pay for accommodation arranged by the insured or any third party on behalf of the insured.

Further is responsible for setting the dates of stay for each covered trip on the basis of the approved treatment plan. The insured will be notified of these dates in good time to enable the insured to make the necessary personal arrangements.

Further will provide a return date for each covered trip after agreement with the treating physician that the insured is able to travel.

If the insured changes the travel dates from those booked and notified by Further, the insured must compensate the insurance company and/or Further for the expenses associated with arranging and notifying new stays, unless the changes are confirmed by Further to be necessary from a health point of view.

The accommodation arrangements include:

- Booking a double or twin room in a three or four star hotel with breakfast included.
- (The choice of hotel will be subject to availability, and the distance to the hospital or attending physician must be within a 10 km radius).
- Meals (except breakfast) and other costs at the hotel are not covered. Any upgrades at the hotel cannot be financed by the insurance company.

Repatriation expenses
If the insured (and/or a living transplant donor) dies outside the country of residence while receiving treatment abroad, the insurance company will pay for the repatriation of the deceased's remains to the country of residence.

This cover is limited to the services and supplies necessary to prepare the deceased's remains for repatriation to the country of residence, including:

- Services provided by the funeral directors providing repatriation from abroad, including embalming and all administrative formalities
- A coffin that fulfils the minimum requirements
- Transport of the deceased's remains from the airport to the designated place of burial in the country of residence.

6.4 Monetary benefits covered during treatment abroad

For each overnight stay in a hospital or clinic in connection with treatment abroad for a covered illness, the insurance will indemnify the insured for daily hospitalisation up to the maximum amount stated in the individual conditions.

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

6.5 Covered treatment expenses after returning from treatment abroad

6.5.1 Covered medical expenses after returning from treatment abroad

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

1. The medication is authorised and approved by a corresponding medical authority or board in the country of residence and its prescription and administration is regulated.
2. The medication can be provided in the country of residence for the period and in the manner necessary to continue the treatment.
3. The medication is available on prescription in the country of residence.
4. The medication is recommended by Further according to the recommendations given by the foreign doctor(s) who treated the insured, if it is necessary for the continued treatment.
5. The medication is prescribed after a hospital stay outside the country of residence of at least three consecutive days, approved by Further/the insurance company in the preliminary medical certificate.
6. Each prescription must not exceed a dose equivalent to two months' consumption.
7. All prescriptions must be issued before the end of the applicable period of cover.

When medication under this section 6.5.1 is purchased in the country of residence, it must be paid directly by the insured. The insurance company will reimburse the insured upon presentation of the prescription and original invoice and proof of payment, provided that the relevant invoice is submitted within 180 days after the expense was incurred.

When the cost of medication is fully or partially covered by the public health insurance in the country of residence or other insurance with Dansk Sundhedssikring, the insurance company will only cover the part of the cost that is not already covered and must therefore be paid directly by the insured. The reimbursement request must clearly state which expenses are paid directly by the insured and which are covered by the public health insurance.

If the recommended medication (or alternatively an equivalent medication with a similar effect), which has been approved by Further, is not authorised or approved in the country of residence as mentioned in section 6.5.1 (1) above or cannot be obtained or is not available to the insured in the country of residence as mentioned in section 6.5.1 (2), and all other conditions in section 6.5.1 (3) up to and including section 6.5.1 (7) are still met, the insurance will also cover expenses for medication outside the country of residence.

In such cases, Further will make the necessary travel and accommodation arrangements for the insured and the designated travelling companion(s) on the terms set out in section 6.3.

6.5.2 Aftercare and follow-up care after returning from treatment abroad

Aftercare and follow-up care is defined in this insurance as any service that includes a specialist-prescribed diagnostic examination and/or monitoring/control after treatment abroad to determine whether the insured is suffering (or is likely to suffer) from aggravation or consequences/complications of the condition treated, with the aim of preventing relapse or recurrence of the same condition.

After returning to the country of residence from treatment abroad, the insurance covers expenses incurred in connection with follow-up care in the country of residence, subject to the following conditions and limitations:

1. The follow-up care is provided at one of the hospitals selected by Further.
2. The follow-up care can be provided in the country of residence for the period and in the manner necessary for the ongoing monitoring.
3. The follow-up care is provided on the recommendation of the foreign physician(s) who treated the insured and consider(s) it necessary for the ongoing control and monitoring.
4. Invoices for the follow-up care will be issued before the end of the applicable period of cover.

When the follow-up care, cf. section 6.5.2, is carried out in the country of residence, it must be agreed and paid for directly by the insured. The insurance company will reimburse the insured upon presentation of original invoice and proof of payment, provided that the relevant invoice is submitted within 180 days after the expense was incurred.

If, after having followed the development of the insured's health, the doctors responsible for the follow-up care in the country of residence indicate that there is a need to work on the basis of other guidelines for follow-up care than those originally established by the foreign doctor, Further will communicate these to the foreign doctor, who may have to approve and confirm reimbursement of such expenses according to the new approved guidelines.

When the cost of follow-up care is fully or partially covered by the public health insurance in the country of residence or other insurance with Dansk Sundhedssikring, the insurance company will only cover the part of the cost that is not already covered and must therefore be paid directly by the insured. The request for reimbursement must clearly separate the costs paid directly by the insured from those covered by the public sector.

At the insured's request, and provided that section 6.5.2 (3) and section 6.5.2 (4) are still complied with, Further can also authorise and arrange follow-up care outside the country of residence. In that case:

- The follow-up care will be provided by the foreign doctor(s) who treated the insured – or by their medical team
- The insurance company will cover the treatment costs for these consultations and diagnostic tests
- Further will make the necessary travel and accommodation arrangements for the insured and the designated travelling companion(s) on the terms set out in section 6.3.

7. What does the insurance 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 incurred for any illness and treatment not specifically stated in section 3.
- Expenses for illness or injury caused as a result of war, acts of terrorism, seismic movements, riots, civil commotion, insurrection, flooding, volcanic eruptions as well as direct or indirect consequences of nuclear reaction or any other extraordinary or catastrophic phenomena and publicly declared epidemics.
- Expenses related to alcohol abuse, drug abuse and/or the use of intoxicants caused by the abuse of alcohol and/or the use of psychotropic drugs, narcotics or hallucinogens.
- Consequences and illnesses arising from attempted suicide and self-harm.
- Expenses incurred by illnesses or ailments that are caused intentionally or fraudulently, arise from the insured's negligent actions or criminal negligence or arise during a criminal offence.
- Injuries where, prior to, during or after Further's claim settlement, the insured has not followed the treating physician's advice, prescriptions or established treatment plan or refuses to receive any medical treatment or undergo further diagnostic analyses or examinations that may be necessary to make a final diagnosis or establish a treatment plan.
- Treatment of pre-existing conditions, defined as any disease or medical condition of the insured, which was reported, examined, diagnosed, treated, or which showed related medically documented symptoms or signs within five years prior to the commencement date of the insurance for each insured shown in the policy.
- Medical treatment that includes gene therapy, somatic cell therapy, tissue-engineered product therapy and CAR-T cell therapy.
- Experimental treatment as well as diagnostic, therapeutic and/or surgical procedures whose safety and reliability have not been widely recognised in the international scientific community as safe, effective and suitable for the disease or disorder in question or which are in the clinical trial stage.
- Treatments required as a result of AIDS (acquired immune deficiency syndrome), HIV (human immunodeficiency virus) or any sequelae thereof (including Kaposi's sarcoma) or other treatment for AIDS or HIV.
- Healthcare services or devices that are not medically necessary for the treatment of the covered illness or treatment.
- Any alternative treatment, service, supply or prescription for a disease or condition for which the best treatment is a transplantation covered by the insurance (cover module 4).
- Any disease or condition caused by the treatment agreed and paid for under this insurance – with the exception of cases where the disease or condition in question is a covered disease or requires treatment covered under section 3.

- Treatment of long-term side effects, relief of chronic symptoms or rehabilitation, including physiotherapy, mobility training, language and speech therapy.
- The following medical expenses (exclusions to section 6.5.1):
  - Costs covered by the public health insurance in the country of residence or by another insurance with Dansk Sundhedssikring
  - Costs related to the administration of medication
  - Costs for the purchase of medication outside the country of residence, unless explicitly authorised by Further/the insurance company
  - Invoices submitted to the insurance company for reimbursement later than 180 days after the expense was incurred.
- The following follow-up care expenses (exclusions to section 6.5.2):
  - Costs covered by the public health insurance in the country of residence or by another insurance with Dansk Sundhedssikring
  - Expenses incurred in violation of the guidelines set by Further
  - Expenses relating to stays at a hospital or treatment centre other than the one approved by Further
  - Invoices submitted to the insurance company for reimbursement later than 180 days after the expense was incurred.
- Expenses incurred in connection with or due to any diagnosis, treatment, service, supply or prescription of any kind in the country of residence with the exception of
  - Medical expenses covered in the country of residence (section 6.5.1)
  - Expenses for follow-up care covered in the country of residence (section 6.5.2).
- Expenses incurred in connection with or due to any diagnosis, treatment, service, supply or prescription of any kind anywhere in the world when the insured cannot be considered to be permanently/legally resident in either Denmark, Germany, Sweden or Norway at the time of the relevant claim.
- Expenses incurred outside the applicable period of cover – with the exception of the circumstances mentioned in section 6.5.
- Expenses incurred before the preliminary medical certificate is issued.
- Expenses relating to stays at a hospital or treatment centre other than the one approved or mentioned in the preliminary medical certificate.
- Expenses incurred in violation of section 5 “Claims procedure”.

- Expenses related to inpatient services, health spas, naturopathic spas, home health care or services provided at a recreation centre, hospice or nursing home for the elderly, even if such services are required or necessary as a result of a covered illness or treatment.
- Expenses incurred for the purchase (or rental) of any prosthetic or orthotic device, corset, bandage, crutch, artificial joint or organ, wig (even when its use is deemed necessary during chemotherapy treatment), orthopaedic footwear, dentures, hernia belts and other similar devices or other similar items – with the exception of breast prostheses following mastectomy and heart valve prosthesis deemed necessary following surgery agreed and paid for under this insurance.
- Expenses incurred for the purchase or rental of a wheelchair, specialised bed, air conditioning unit, air purifier and other similar items or equipment.
- Medication that is not dispensed from a certified pharmacy or that can be purchased over the counter.
- Expenses incurred for the use of alternative medicine, even when prescribed by a doctor.
- Expenses incurred for medical supervision or hospitalisation in the event of cognitive disorders, senility or impairment of brain function – regardless of the stage of development of the disease.
- Fees for interpreter, telephone and other expenses for personal needs not related to medical treatment or other services provided to family, relatives or other companions.
- Expenses incurred by the insured, relatives or other companions, with the exception of those expressly covered by the insurance.
- Treatment expenses that are not customary and reasonable in terms of price.
- Accommodation and transport expenses arranged by the insured, the travelling companion or a living donor.

8. 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. 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.

8.1 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, unless otherwise stated in the insurance contract.

8.2 Sum insured
The sum insured is stated in the insurance contract. The amount is stated for each insured. The amount is fixed and is not adjusted. If an insured uses up the sum insured, no further expenses are covered. The sum insured applies as an overall maximum, regardless of whether multiple covers or options have been taken out.

8.3 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 email 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 period of insurance
- 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.

8.4 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 terminate 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 terminated 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.

8.5 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.

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 ceases at the end of a month if you no longer have a registered address in the Nordic region or Germany. This does not apply in the event of posting.

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

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 period of insurance is covered for up to six 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

For co-insured family members 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 27 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 request for continuation must be received by the company no later than 15 days after the date on which the company scheme cover ceases.

Reimbursement of bills

Bills for approved treatments and/or transport must always be submitted no later than 180 days after the treatment date in order for you to be eligible for reimbursement.

8.6 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.

Co-insured spouses/partners are obliged to inform us if they divorce or leave an employee covered by the insurance.

When you resign from your position
When reporting a disease/injury or if you request treatment, you are obliged to inform us if you have resigned or are leaving the company.

The insurance covers authorised claims reported during the period of insurance for up to six months from the date you leave the company.

You can apply to continue the insurance, cf. section 8.5.

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.

8.7 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. In certain cases, we may disclose your personal data to suppliers with whom we co-operate.

8.8 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 disease/injury and is always processed in accordance with the Danish Health Act's requirement for confidentiality (section 40 of the Health Act: "A patient is entitled to expect healthcare professionals to observe secrecy about what they learn or suspect about health conditions and other confidential information during the exercise of their profession").

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.

8.9 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.

8.10 Time limitation

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

8.11 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 reviewed.

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 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.

8.12 If you want to know more

If you want to know more about your insurance, you can contact Dansk Sundhedssikring by phone on +45 70206121 or by email at sundhedsforsikring@ds-sundhed.dk.

You can find more information on our website: ds-sundhed.dk.