DANSK | SUNDHEDS SIKRING

Terms - Trade and Industry Health Insurance

Full-time coverage

Version 6.0 | Forsikringsselskabet Dansk Sundhedssikring A/S | Q1 | 2021

DANSK SUNDHEDS SIKRING

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Forsikringsselskabet Dansk Sundhedssikring A/S
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1 Basis for the agreement

These insurance conditions are valid from 1 January 2021 and replaces previous insurance conditions.

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

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

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

The policyholder has a duty to inform their employees/ members about what the insurance covers, as stated in the insurance contract with any addenda.

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

Company
This means Dansk Sundhedssikring A/S, referred to in the conditions as Dansk Sundhedssikring.

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

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

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

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

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

The insurance only covers diseases/injuries related to the company with which we have entered into the insurance contract.

2 Who the insurance covers

The insurance contract applies between Dansk Sundhedssikring and the company named as the policyholder in the contract.

The insurance can be taken out by companies registered with a VAT number in Denmark, and the company must be located in Denmark, unless otherwise stated in the contract.

The insurance covers the employees who are subscribed and named in the insurance contract.

The insurance can be purchased for an employee or a group of employees, as a compulsory or voluntary scheme. There is no upper age limit for the employees.

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Employees employed in reduced-hours jobs or jobs with light duties are covered, but not for the disorders that are the reason for the employee having a reduced-hours job or job with light duties.

The insured party must have a permanent National Registration Office address in Denmark (excluding Greenland and the Faroe Islands), have a Danish health insurance card and be entitled to receive Denmark's public health insurance benefits or be a resident of Norway, Sweden or Germany and be entitled to receive benefits corresponding to the public health insurance benefits through public or private cover in their country of residence. Exceptions will be stated in the contract.

Expatriates and any co-insured party stationed abroad with the employee, are only covered for examination and treatment in Denmark. Transport costs to and from Denmark are not covered.

2.1 Subscribing and unsubscribing employees

The company must always keep us informed of which employees should be subscribed or unsubscribed from the insurance policy and must ensure that we have an updated list of employees covered by the scheme.

Dansk Sundhedssikring offers the option to make adjustments free of charge twice in connection with the renewal date. If there are adjustments in addition to this, an adjustment fee of DKK 2,500 will be charged per adjustment. Adjustments can only be made during the current year and no more than 3 months in arrears. The company pays for claims payments that Dansk Sundhedssikring has made for employees who have been unsubscribed back in time.

2.2 Co-insured

It is possible to co-insure a spouse/cohabitant/child for a separate price. Children who can be subscribed are your biological children and/or adoptive children and your spouse's/cohabitant's biological children and/or adoptive children who have their National Registration Office address with you. A spouse's/cohabitant's biological children and/or adoptive children, who do not have their National Registration Office address with you, can be co-insured if your spouse/cohabitant has taken out a voluntary insurance.

Children can be co-insured until their 21st birthday. It is possible to continue the coverage by a similar arrangement until the children reach the age of 27. The insured party must always notify us if changes occur in their relationships that affect who should be covered by the insurance contract.

2.3 Collective child cover

If the company has purchased collective child cover, your children are automatically and collectively co-insured under the same conditions as you, unless otherwise stated in the cover, until they reach the age of 21. If an agreement has been reached for another age for the children, it will be stated in the contract. The children covered are your biological children and/or adoptive children and your spouse's/cohabitant's biological children and/or adoptive children, irrespective of their place of residence. Foster children may be included if they have the same registered address as the main insured party. The collective child cover will end if your cover expires.

2.4 Qualifying provisions

There is no qualifying period for compulsory company schemes for existing disorders, with the exception of the special provisions for chronic disorders and for the optional cover "Addiction therapy".

For co-insured parties, for private clients and for voluntary schemes, there is a 6 months qualifying period for existing diseases and injuries. This means that you must have been covered by the insurance for 6 months before costs are covered for the examination and treatment of disorders that have arisen and/or been diagnosed before the insurance came into effect. Diseases and injuries that arise after the insurance comes into force will be covered on the basis of the applicable insurance conditions.

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

3 What the insurance covers

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

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

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Examination and treatment in Sweden, Norway or Germany can take place in agreement with us if we find it reasonable and relevant. The expenses must not, according to our assessment, exceed the total cost of a similar examination and treatment carried out in Denmark.

Examination and treatment in Greenland or the Faroe Islands are never covered. This also applies if you have a registered address in Denmark but are staying in Greenland or the Faroe Islands. This does not apply if otherwise provided by the individual contract.

4 Using the insurance

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

4.1 Doctor's referral

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

4.2 Examination and treatment must be approved

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

4.3 Acute treatment is not covered

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

4.4 Travel and stays abroad

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

4.5 Non-appearance for treatment

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

4.6 Ongoing and planned treatment

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

4.7 Expenses for treatments

All expenses must be reasonable and necessary in our opinion in relation to the expected outcome.

The insurance covers your actual expenses after contributions from the public health insurance system are deducted. This means that in cases where public health insurance covers a portion of the cost, we will offset that portion and pay your share (self-payment). If you are a member of Sygeforsikringen "danmark", then we will receive and offset your possible subsidy for the treatment.

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

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

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4.7.2 Rates for physiotherapy, chiropractic and treatment by a psychologist

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

If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient's share at the rate applicable to general physiotherapy, which is index-adjusted twice a year.

In cases where we cover team training at a physiotherapist as part of the treatment, team training is covered corresponding to the patient's share for team training in general physiotherapy, which is index-adjusted annually.

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

For psychologist treatment referred by a doctor, we cover the patient's share of the treatment after a subsidy from the public health insurance. In the case of treatment by a psychologist without an agreement with the public health insurance (service provider number), the therapist's fee will be covered up to a maximum of DKK 1,000 per treatment.

Other treatment rates are stated in the individual cover.

4.8 Choice of therapist

The treatment should, in our opinion, be expected to cure the disorder or significantly and permanently improve the state of health. Treatments of a preventive nature are not covered.

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

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

The insurance only covers the types of treatment mentioned in the insurance conditions under the various covers and any optional cover.

For physiotherapy, chiropractic and psychological treatment, we recommend treatment in our quality-assured nationwide network. However, you have the option to choose a therapist yourself. For treatment in our network, we endeavour to ensure that your treatment begins within 4-5 working days and within a maximum of 10 working days.

For examination and treatment by a medical specialist, the first examination and/or treatment will be initiated within 10 working days in the public or private healthcare service. We select the therapist/treatment centre. The 10 working days do not apply to medical specialists in psychiatry (psychiatrists).

The treatment method must always be approved by us.

No costs are covered for examination or treatment performed by you, your family members or any company belonging to any of these.

4.9 Assessment of treatment requirements

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

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

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

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

4.10 Making a claim

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

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The quickest way to file a claim is by reporting it online via our website: ds-sundhed.dk. Claims filed will be treated quickly and, in most cases, from one day to the next. Claims can also be filed by telephone.

If you have questions about your insurance policy or if your inquiry concerns an existing case, you can contact the healthcare team on weekdays by telephone +45 70206121 or at the e-mail address: sundhedsteam@ds-sundhed.dk.

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

5 Basic coverage

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

The covers are described in the following sections:

5.1 SundhedsNavigator
Our health team consisting of experienced doctors, nurses, physiotherapists and other healthcare professionals has many years' experience from various areas of specialisation and they offer professional advice on health and disease. You are offered consultation with a nurse or doctor by telephone for all health problems, including those that do not require actual treatment or which are not covered by the insurance.

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

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

5.2 Chronic diseases
The insurance covers the examination and treatment of chronic diseases and disorders that arise during the insurance period, for up to 6 months from the date of diagnosis, if we consider that treatment will cause a significant and lasting improvement to the condition.

Chronic diseases and disorders that have occurred and/or are diagnosed before the insurance period, are not covered.

We define chronic diseases as diseases, conditions and disorders that our doctors consider are persistent and cannot be cured, and where there is no curative treatment.

The healthcare team always offers assistance for all chronic diseases with counselling, guidance on the public health system's treatment offers, patient rights, waiting times, examination and treatment guarantees and help with booking appointments in the public healthcare system.

5.3 Complications from chronic diseases
Examination and treatment of complications that arise during the insurance period as a direct consequence of a chronic disease, are covered for up to 6 months from the date of diagnosis. It is a prerequisite for cover that we consider that treatment will cause a significant and lasting improvement to the condition. Complications that occurred before the insurance came into force are not covered.

5.4 Pain diagnosis
Examination and treatment of long-term pain issues at e.g. a pain clinic or headache clinic, and pain treatment associated with cancer, are not covered by the insurance. The healthcare team helps with counselling in the further process.

5.5 Examination and treatment by a medical specialist
The insurance covers reasonable and necessary examination and treatment of a coverable disease/injury carried out by a relevant medical specialist in a hospital or clinic.

We cover reasonable examinations that we consider necessary for a diagnosis, and treatment performed by the relevant medical specialist in those cases where we consider that the treatment can cure or significantly and permanently reduce the disease.

The insurance does not cover private expenses during hospitalisation or similar.

Doctor's referral

You must always have a valid referral or recommendation from your doctor. If your doctor considers that you require an examination or treatment, you will be referred to a relevant medical specialist in the public healthcare system. This referral can be used when you wish to use your insurance. Ultrasound scanning, X-ray examinations and MRI scans also require a referral.

10-day examination and treatment guarantee

You are guaranteed that a coverable examination and/or treatment will be initiated within 10 working days in the private or public healthcare system, after we have received and approved your notification.

If we need more information, such as a doctor's referral or other relevant information, the 10 working days will start after we have received and approved the necessary information.

If we consider that it is not possible for you to obtain an appointment within 10 working days in the public health service, including a free choice of hospital and activation of the right to timely examination and treatment, we may instead refer you for examination and/or treatment at a private hospital or a private clinic in our network. You must always use the treatment centre we refer you to.

In cases where the waiting time in the private healthcare system is the same as in the public system, we can choose that the public system should be used.

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

The examination and treatment guarantee does not cover:

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

5.5.1 Skin conditions

The insurance covers skin conditions which we consider are affecting your health condition. Skin diseases that we consider cosmetic or chronic are not covered. These are e.g. benign birthmarks and spots, acne, eczema and all kinds of warts and damage caused to the skin by the sun. No recurrent skin disorders or relapses are covered, e.g. elsewhere on the body. We always help with advice, navigation of the public healthcare system and help with booking appointments for all skin disorders.

5.5.2 Skin cancer (basal cell carcinoma)

If we have covered treatment of skin cancer (basal cell carcinoma), the insurance will not cover if the disease returns and requires a new examination and/or treatment. The insurance never covers treatment with Mohs surgery or similar types of treatment.

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5.5.3 Allergy diagnosis
The insurance covers an examination for allergy in order to make a diagnosis. The examination must be in writing, issued by a doctor and approved by us.

5.5.4 Cataracts
Cataracts are considered a chronic disorder. Cataracts diagnosed during the insurance period, including the development of secondary cataracts, are covered for up to 6 months from the date the, or the secondary cataracts, cataracts are diagnosed. Cataracts (and secondary cataracts), that are diagnosed before the insurance came into force, are not covered.

5.5.5 Varicose veins
Varicose veins are considered cosmetic and are only covered if, in our opinion, there are serious symptoms such as loss of driving license, sick leave and deep inflammation.

5.5.6 Cancer
The insurance covers the examination and treatment of cancer diseases if the diagnosis is made during the insurance period. If the waiting period for the examination and/or treatment in the public healthcare system is at the same level as in the private sector, the public system must always be used.

Forms of cancers that require complicated treatment methods, such as chemotherapy and radiation therapy, as well as emergency or experimental treatment, are exempt from cover. Treatment is only covered if it is performed at private hospitals in Denmark with whom we cooperate. In case of cancer diseases that form part of a comprehensive treatment package in the public healthcare system, the public offer must always be activated and used. The healthcare team helps with counselling in the further process.

5.5.7 Heart disease
For the treatment/operation of heart disease, we refer to the public healthcare service because we regard it as emergency treatment. We help with counselling in the further process.

5.5.8 Addiction
Addiction disorders of any kind are not covered by the basic insurance. The healthcare team offers counselling in connection with alcohol and drug addiction and can advise on public treatment services.

5.5.9 Follow-up examinations
The insurance covers the necessary outpatient follow-up examination after coverable surgery for up to 6 months after the last treatment date.

The examination must be prescribed by the relevant medical specialist and be reasonable and necessary, in our opinion. The insurance does not cover repeated check-ups.

5.5.10 Re-operation
The insurance covers re-operation after a coverable operation if the primary operation has been performed at a treatment centre designated by us. The re-operation must be prescribed by a medical specialist and approved by Dansk Sundhedssikring's doctor. We will refer to a treatment centre.

5.5.11 Second opinion
In certain cases, the insurance covers consultation with a relevant medical specialist if you:

- Have a life-threatening or particularly serious disease or injury.
- Are faced with the choice of receiving particularly risky treatment, which may be life-threatening or result in permanent injury.

If we consider that you should be offered a second opinion, we will refer you to a relevant medical specialist in the public or private healthcare system.

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

5.5.12 Medicine expenses
The insurance covers reasonable expenses for self-payment of prescription medicines in direct connection with a coverable procedure at a treatment centre designated by us. The medicine must be prescribed by the attending medical specialist and be necessary for the procedure performed. Medicine expenses are covered for up to 6 months from the date of the procedure. Costs for over-the-counter medicine are not covered. This also applies if the medicine is available both on prescription and over the counter.

5.5.13 Temporary aids
The insurance covers reasonable expenses for personal temporary aids, which we consider necessary in connection with a coverable procedure or treatment.

The aid must be prescribed by the attending medical specialist. Temporary aids, including hired aids, are covered for a maximum of 6 months. Expenses for aids for outpatient rehabilitation are not covered.

Expenses for aids that can be received through the public grants for aids are not covered. Orthopaedic footwear, a CPM machine and similar are not covered.

5.5.14 Rehabilitation after surgery

The insurance covers outpatient rehabilitation at a physiotherapist and chiropractor in direct connection to a coverable procedure in the musculoskeletal system. The musculoskeletal system means tendons, muscles and joints of the back, shoulders, neck, knees, elbows, hip and wrists. The rehabilitation must be prescribed by the attending medical specialist. Recreational and treatment stays are not covered.

You must have a valid doctor's referral for physiotherapy and use a therapist who has an agreement with the public health insurance system. If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient's share at the rate applicable to general physiotherapy, which is index-adjusted twice a year. Team training at a physiotherapist is covered if it is part of a covered course of rehabilitation and is approved by us. Team training is covered corresponding to the patient's share for team training, which is index-adjusted annually. For chiropractic treatment, the amount corresponding to the patient's share is covered according to the rate applicable for general chiropractic.

Rehabilitation in Dansk Sundhedssikring's network

The insurance covers the necessary number of treatments per disease/injury based on a professional assessment. You will be offered a quick appointment at a quality-assured clinic and we will settle directly with the therapist.

Rehabilitation outside Dansk Sundhedssikring's network

The insurance covers the necessary number of treatments by a physiotherapist or chiropractor you have chosen yourself for up to 6 months per disease/injury calculated from the date of the procedure. The treatments are allocated in portions. If more treatments are needed, contact the healthcare team, who will evaluate and allocate additional treatments. As part of our assessment, we may request a status report or treatment plan from your therapist. You should settle with the therapist yourself.

Once your course of treatment is complete, send us a copy of all the original bills. Bills must be submitted no later than 3 months after the final treatment in order to qualify for a refund.

5.5.15 Home help/home nurse

The insurance covers reasonable and necessary expenses for temporary assistance in the home in direct connection with a coverable operation initiated by us. As a necessary part of the treatment, the help must be prescribed by the attending medical specialist. Temporary help for cleaning, shopping, personal hygiene and dressing/undressing is covered for a maximum of 6 months from the date of discharge. Home help is not covered in those cases where the need can be attributed to old age, dementia, senility or similar. We can choose that the service must be provided by a home service company designated by us.

5.5.16 Transport expenses

The insurance covers reasonable transport costs in Denmark between home and the treatment centre in connection with medical specialist care at the hospital/clinic. The transport must always be agreed with and approved by us. Transport expenses are not covered for medical specialists in psychiatry, emergency trauma counselling, hospice and terminal care or for the optional coverage "Addiction counselling". Expenses for taxies are not covered. Transport expenses for medical specialist care abroad are not covered.

Requests for refund of transport bills must be submitted no later than 3 months after the treatment is completed in order to qualify for reimbursement.

Transport to and from examination and treatment

The insurance covers transportation costs to and from coverable examination/treatment by a medical specialist in cases where we refer you to a hospital or clinic more than 75 km from your place of residence. The cover is equivalent to the state's lowest rate for driving in your own car or the least expensive form of public transport.

Ambulance transport (recumbent)

The insurance covers recumbent ambulance transport to/from the home and the coverable admission/procedure. Recumbent transportation must be prescribed by the attending medical specialist. It is a prerequisite for cover that we consider that for health reasons, you cannot be transported by car, even as a passenger, or by public transport, and that your transport is not covered by other means. We can choose that the service must be provided by a supplier designated by us.

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Medical companion
The insurance covers reasonable transportation costs for one medical companion, if we consider that your health condition requires that you should have a companion. Companion accommodation is not covered.

5.7 Physiotherapist and chiropractor
The insurance covers reasonable and necessary treatment by a physiotherapist or chiropractor in Denmark after referral by the healthcare team. It is a prerequisite for cover that there is a medically documented need to receive treatment and that the treatment ensures progression/improvement of the condition. Treatments of a preventive and maintenance nature are not covered.

Based on a medical assessment, the healthcare team will provide a referral to the relevant treatment. To ensure that you always receive the correct treatment, the healthcare team will continuously assess how many treatments you need and whether you are receiving the correct treatment.

You must always have a valid referral for physiotherapy, and the physiotherapist or the chiropractor must have an arrangement with the public healthcare insurance (service provider number).

If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient's share at the rate applicable to general physiotherapy, which is index-adjusted twice a year. For chiropractic treatment, the amount corresponding to the patient's share is covered according to the rate applicable for general chiropractic. Team training at a physiotherapist is covered if it is part of a covered course of treatment and is approved by us. Team training is covered corresponding to the patient's share for team training, which is index-adjusted annually.

Treatment in Dansk Sundhedssikring's network
The insurance covers the necessary number of treatments per disease/injury based on a professional assessment. You will be offered a quick appointment at a quality-assured therapist and we will settle directly with the therapist.

Treatment outside Dansk Sundhedssikring's network
The insurance covers the necessary number of treatments by a physiotherapist or chiropractor you have chosen yourself for up to 6 months per disease region (knee, shoulder, hip, neck, back, etc.). The treatments are allocated in portions.

As part of our assessment, we may request a medical assessment or a written justification for continued treatment from the physiotherapist or chiropractor. You should settle with the therapist yourself. Once your course of treatment is complete, send us a copy of all the original bills. Bills must be submitted no later than 3 months after the final treatment in order to qualify for a refund.

In cases where you have started treatment with a therapist outside of our network, we can decide that continued treatment must be with a therapist designated by us. This could apply, for example, if you want to change therapists or if we consider that the treatment is not having the desired effect.

GLA:D training for hip and knee osteoarthritis
If you are diagnosed with hip or knee osteoarthritis, we may choose based on a professional evaluation to cover a GP-referred GLA:D training plan. You must have a valid GP referral and use a healthcare provider that has an arrangement with the health insurance (provider number). If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient's share at the rate applicable to general physiotherapy, which is index-adjusted twice a year.

The length of the course of treatment depends on a professional assessment, and we can decide that the treatment should take place in our network or with a therapist appointed by us. A maximum of one GLA:D treatment plan may be covered during the insurance period per area of illness (knee or hip). We consider the treatment plan to have been completed if you choose to discontinue treatment ahead of time. In cases where GLA:D training cannot cover for your problem, coverage for regular physical therapy will apply. The above provisions also apply if you are covered by Option B, "Physiotherapy without referral from doctor".

GLA:D Back
If you are diagnosed with long-term (more than 3 months) or persistent back pain that affects your health and your everyday life, we may choose based on a professional evaluation to cover a GP-referred GLA:D training plan. You must have a valid GP referral and use a healthcare provider that has an arrangement with the health insurance (provider number). If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient's share at the rate applicable to general physiotherapy, which is index-adjusted twice a year.

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The length of the treatment course depends on a professional assessment, and we can decide that the treatment should take place in our network or with a therapist appointed by us. A maximum of one GLA:D Back treatment plan may be covered during the insurance period. We consider the treatment plan to have been completed if you choose to discontinue treatment ahead of time. In cases where GLA:D training cannot cover for your problem, coverage for regular physical therapy will apply. The above provisions also apply if you are covered by Option B, “Physiotherapy without referral from doctor”.

Treatment in Sweden and Norway

If you reside in Sweden or Norway, we cover approved treatment in your country of residence. We cover grants for treatment corresponding to the Danish amounts/tariffs. We can choose that it must be a therapist in our network or at a therapist designated by us.

5.8 Psychologist and psychiatrist

The insurance covers reasonable and necessary treatment prescribed by a doctor with a psychiatrist or authorised psychologist (authorised MSc (Psychology) in Denmark. Consultations at a neuropsychologist are not covered. If you are referred for a treatment package in the public healthcare system, this offer must always be used.

In cases where we assess from a healthcare perspective that the examination and/or treatment procedures can best be performed in the public system, e.g. in the case of a mental disease diagnosis that is part of the public treatment package in psychiatry, or if there is no permanent recovery after previously attempted treatment (e.g. if you have received therapy from a psychologist and/or psychiatrist for a recurrent disease without lasting recovery), we can direct that the public healthcare services should be activated and used. We offer guidance regarding the use of public services.

Crisis prevention and support helpline

With a health insurance policy at Dansk Sundhedssikring, you can call and get personal advice, guidance and support for well-being-related problems that do not require actual treatment. The crisis prevention and support helpline is managed by an experienced, in-house counselling team, all of whom have a professional background within health and can help you prevent and manage problems before they become major issues.

It includes counselling for employees, managers, HR and for the co-insured. The counselling covers, e.g.:

- Private well-being problems pertaining to e.g. personal crises, children, cohabi-tation, divorce, lifestyle, and substance abuse.
- Work-related well-being problems, e.g. job burnout, dismissal, bullying, and con-flict.
- Professional sparring for managers and HR.

A doctor’s referral is not required, and the counselling team assesses whether a follow-up interview is needed. The counselling team is subject to a duty of confidentiality.

The crisis prevention and support helpline is open on weekdays between 9:00 AM to 4:00 PM. You call via the main number at +45 70206121 and dial onto the line via the menu.

Hotline for preventative stress

When you have a health insurance plan with Dansk Sundhedssikring, you can get help via the hotline for stress. Here you can get quick and personal counselling at the first symptoms of stress. The line is handled by a team that is particularly experienced counselling team within healthcare. No GP referral is required, and the counselling team determines whether counselling with a possibility for follow-up is needed, or if you require a course of treatment. In cases where treatment is considered to be needed, coverage for general psychological counselling will be applicable. The telephone counselling is available every weekday from 9:00 to 16:00. You enter the line via the menu when you call our main number +45 70206121.

5.8.1 Psychologist

The insurance covers medically justified individual treatment at a psychologist. It is a prerequisite for cover that we consider that you have a symptomatic mental disease/injury and that there is a medically documented need for treatment. We assess whether you need a written medical referral or recommendation.

The treatment must ensure progression/improvement of the condition. Mental disorders which, in our opinion, cannot be cured or permanently improved are not covered.

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Based on a medical assessment, the healthcare team will provide a referral to the relevant treatment. We offer different forms of treatment for e.g. stress and anxiety. We will continuously assess how many treatments you need and whether you are receiving the correct treatment.

Couple therapy, family therapy, coaching, self-development, supportive and maintenance conversations, as well as psychological therapy of a preventive nature are not covered.

Treatment in Dansk Sundhedssikring's network
The insurance covers the necessary number of treatments per disease/injury based on a professional assessment. You will be offered a quick appointment at a quality-assured therapist and we will settle directly with the therapist.

Treatment outside Dansk Sundhedssikring's network
The insurance covers the necessary number of treatments by a psychologist you have chosen yourself for up to 6 months per disease/injury. Children are covered for a maximum of 5 treatments per calendar year, even in case of multiple injuries. The treatments are allocated in portions. If further treatments are required, contact the healthcare team, who will evaluate and allocate additional treatments.

As part of our assessment, we may request a medical assessment or a written justification for continued treatment from the psychologist.

If you have a referral from your doctor, we cover the patient portion of the treatment after a grant from the public health insurance system. For treatment at a psychologist without a service provider number, the psychologist's rate is covered up to a maximum of DKK 1,000 per treatment. You should settle with the therapist yourself. Once your course of treatment is complete, send us a copy of all the original bills. Bills must be submitted no later than 3 months after the final treatment in order to qualify for a refund.

In cases where you have started treatment with a therapist outside of our network, we can decide that continued treatment must be with a therapist designated by us. This could apply, for example, if you want to change therapists or if we consider that the treatment is not having the desired effect.

For children, treatment in our network cannot be covered if treatment has started at a psychologist of your own choice. The age for children is stated in the agreement.

5.8.2 Different therapies adapted to your needs
To ensure optimal treatment of your problem, we can refer to different forms of treatment, such as:

- Individual course of therapy at a psychologist (treatment in our network or by a therapist of your own choosing).
- Telephonic therapy from experienced psychologists, organisational psychologists and psychotherapists via networks.
- On-line stress management plan through the network.
- Consultations with experienced, quality-assured psychotherapists with whom we have a collaboration agreement.
- Tripartite conversations in connection with work-related stress (not applicable to co-insured persons).
- Cool Kids/Chilled (anxiety therapy programme for children aged 7-12 and 13-17).

Psychotherapists
In connection with e.g. stress, depression and anxiety that require therapy, we may refer you in relevant cases to experienced, quality-assured psychotherapists with whom we have a collaboration agreement and who have special experience with various psychological issues. The treatment is needs-based and is allocated in portions based on a professional assessment.

Telephonic course of therapy
For disorders with mild to moderate symptoms requiring treatment (e.g. stress and anxiety), we can choose to refer you to a course of therapy by telephone provided by experienced psychologists and psychotherapists in our network. The number of treatments is needs-based and determined on the basis of a professional assessment.

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Trialogue for work-related stress

For work-related stress, we can refer you to a tripartite course of treatment between you, your manager (or HR) and a psychologist based on a professional assessment and in consultation with you. The course of treatment focuses on the labour market situation, for instance, when there is need for help with maintaining or re-turning to the workplace. The course of treat-ment is not preventive in nature and does not include any problems other than stress. The course of treatment is therefore not suitable in the event of prolonged stress disorder, medical treatment or in severe stress cases with long-term illness.

We will find you a psychologist who is specialized within stress and stress management in the workplace. The length of the course of treat-ment depends on the healthcare provider's as-sessment.

In cases where you have work-related stress but where trialogues at the workplace are not the right solution, coverage for regular psychological counselling will be applicable.

Cool Kids/Chilled anxiety treatment programme for children

For psychological therapy for anxiety disorders with a doctor's referral during the insurance period, we can refer to the anxiety treatment programme Cool Kids for children aged 7-12 and the Chilled programme for children aged 13-17, based on a professional assessment and in consultation with you.

The programme is offered as a group process for children/young people and their parents, or in individual cases as an individual process.

The therapy begins with an individual preliminary consultation with a psychologist, where it is decided whether the child is in the target group. We refer to a psychologist, and the length of the process will depend on a professional assessment. One course of anxiety therapy is covered during the insurance period. We consider the process to be completed if you choose to discontinue the treatment prematurely.

In cases where we do not cover the anxiety programme, e.g. if the psychologist considers that the programme is not suitable, cover for ordinary psychological counselling will apply.

Treatment in Sweden and Norway

If you reside in Sweden or Norway, we cover approved treatment in your country of residence. We cover grants for treatment corresponding to the Danish amounts/tariffs. We can choose that it must be a therapist in our network or at a therapist designated by us.

5.8.3 Trauma counselling

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

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

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

There is no requirement for a doctor's referral. The healthcare team assesses whether emergency trauma counselling is required or whether other treatment is required.

If we consider that you need emergency trauma coun-selling, we will find a psychologist for you in our network. You will have telephone contact with the psychologist within 3 hours after the notification is approved. The sub-sequent process will depend on the nature of the incident and the therapist's professional assessment. There can be a maximumof 5 consultations per incident.

In case of notification more than 48 hours after the cause of the crisis, cover for ordinary psychological counselling will always apply. Emergency psychological coun-selling abroad is not covered. Debriefing of groups is not covered, unless it is included as part of the cover for an approved emergency course of treatment.

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5.8.4 Psychiatrist
The insurance covers necessary consultations referred by a doctor at a psychiatrist, if we consider that it is possible to achieve a significant and lasting improvement in the state of health.
The consultations are allocated in portions and we refer to a therapist. Conversational therapy at psychiatrists is not covered. Costs for expenses for medicine are not covered.

5.9 Hospice and terminal care
The insurance covers an approved stay at a Danish hospice in connection with a terminal diagnosis made during the insurance period for up to 3 months, up to a maximum of DKK 30,000.

The stay must be prescribed in writing by a doctor and we must receive a copy of the medical records indicating that the diagnosis is terminal.

Alternatively, we can allocate terminal care in your home provided by a home nurse for up to 3 months, up to a maximum of DKK 30,000.

The maximum expenses that can be covered for hospice or terminal care is DKK 30,000 for the entire insurance period. We may decide that it must be a hospice or a supplier designated by us.

6 Optional covers

The insurance contract shows which optional covers are attached to the insurance. The combined insurance conditions apply for all optional covers, but with the detailed rules and exceptions shown in the individual covers.

6.1 Option A Acupuncture, reflexology, osteopathy and dietician
The option covers treatment by an acupuncturist, reflexologist, osteopath or dietician after a referral from the healthcare team. You can choose which therapist you wish to use. If you wish, the healthcare team can help you to find a therapist. Treatment in Denmark is covered.

Acupuncture, reflexology and osteopathy are covered by disorders of the musculoskeletal system. The musculoskeletal system means tendons, muscles and joints of the back, shoulders, neck, knees, hip, elbows and wrists.

The treatments must be performed by a RAB-approved reflexologist or acupuncturist, registered osteopath (member of Registrerede Osteopater Danmark) or an authorised clinical dietician. You should settle with the therapist yourself. Once your course of treatment is complete, send us a copy of all the original bills. Bills must be no later than 3 months after the final treatment in order to qualify for a refund.

Acupuncture
Acupuncture treatment is covered for coverable disorders of the musculoskeletal system.

Cover is provided for the number of reasonable and necessary treatments that can be justified for healthcare reasons, up to a maximum of 10 treatments per disease/injury and a maximum of 10 treatments per calendar year. The treatments should, in our opinion, lead to a significant and lasting improvement in the condition, and after a medical assessment we may refuse to cover treatment of a recurring disorder/problem. The treatments are allocated in portions and we will continuously assess how many treatments are necessary. The insurance covers the psychologist's rate up to a maximum of DKK 500 per treatment.

Reflexology
Reflexology treatment is covered for coverable disorders of the musculoskeletal system. Cover is provided for the number of reasonable and necessary treatments that are justified for health reasons, up to a maximum of 10 treatments per disease/injury and up to a maximum of 10 treatments per calendar year. The treatments should, in our opinion, lead to a significant and lasting improvement in the condition, and after a medical assessment we may refuse to cover treatment of a recurring disorder/problem.

The treatments are allocated in portions and the healthcare team will continuously assess how many treatments are necessary. The insurance covers the psychologist's rate up to a maximum of DKK 500 per treatment.

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Osteopathy
Osteopathy is covered for a coverable disorder in the musculoskeletal system. Cover is provided for the number of reasonable and necessary treatments that can be justified for healthcare reasons, up to a maximum of 10 treatments per disease/injury and a maximum of 10 treatments per calendar year.

The treatments should, in our opinion, lead to a significant and lasting improvement in the condition, and after a medical assessment we may refuse to cover treatment of a recurring disorder/problem. The treatments are allocated in portions and the healthcare team will continuously assess how many treatments are necessary. The insurance covers the therapist's fee, up to a maximum of DKK 650 for the first treatment and DKK 500 for subsequent treatments.

Dietician
Medically justified treatment by an authorised clinical dietician is also covered. Cover is provided for the number of necessary treatments that can be justified for healthcare reasons, up to a maximum of 10 treatments per disease/injury and a maximum of 10 treatments per calendar year. The preparation of 1 dietary plan is covered per disease/injury.

The treatments should, in our opinion, lead to a significant and lasting improvement in the condition, and after a medical assessment we may refuse to cover treatment of a recurring disorder/problem. We assess whether you need a written medical referral or recommendation.

The treatments are allocated in portions and the healthcare team will continuously assess how many treatments are necessary. The insurance covers the therapist's fee, up to a maximum of DKK 900 for the first treatment and DKK 500 for subsequent treatments.

If diabetes, elevated cholesterol, cardiovascular disease, bowel disorder, uric acid, coeliac disease or PCO/PCOS are diagnosed during the insurance period, one course of treatment (maximum 10 treatments) can be covered during the insurance period. The insurance does not cover dietary treatment for desired pregnancy, lactation, underweight, sports nutrition, food allergy, intolerance and similar conditions, as well as psychological disorders, including stress, depression, eating disorders and overeating. The insurance covers gp-referred treatment from a dietian for severe obesity during pregnancy as well as postpartum weight that requires treatment (BMI over 30).

6.2 Option B Physiotherapy without referral from doctor
With this option, there is no requirement for a doctor's referral for physiotherapy. If we consider that there are medical reasons for treatment, the healthcare team can refer you directly for treatment. We will refer you to your doctor in cases where we consider that, for medical reasons, you should consult with a doctor before starting any treatment.

The treatment must ensure progression/improvement of the condition. Treatments of a preventive and maintenance nature are not covered.

Treatment in Dansk Sundhedssikring's network
The insurance covers the necessary number of treatments per disease/injury based on a professional assessment. You will be offered a quick appointment at a quality-assured clinic and we will settle directly with the therapist.

Treatment outside Dansk Sundhedssikring's network
The insurance covers the required number of treatments at your chosen physiotherapist and chiropractor for up to 6 months per disease region (knee, shoulder, hip, neck, back, etc.). The treatments are allocated in portions.

If further treatments are required, contact the healthcare team, who will evaluate and allocate additional treatments. As part of our assessment, we may request a medical assessment or a written justification for continued treatment from the physiotherapist. The insurance covers the therapist's fee, up to a maximum of DKK 465 for the first treatment and DKK 300 for subsequent treatments.

You should settle with the therapist yourself. Once your course of treatment is complete, send us a copy of all the original bills. Bills must be submitted no later than 3 months after the final treatment in order to qualify for a refund.

6.3 Option C Addiction therapy
The option covers reasonable treatment costs for abuse of and addiction to:

- Alcohol.
- Prescription medicine.
- Narcotics (intoxicants covered by the Act on Euphoriant Substances).
- Diagnosed ludomania (addiction to gambling).

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No other types of addiction are covered except those mentioned above. “Addiction therapy” is not covered until you have been covered by the policy for 6 months. It is possible to transfer seniority in connection with direct transfer from another company, where you also had similar cover.

Doctor’s referral
The treatment must be prescribed in writing by a medical practitioner and we must consider that there is a realistic chance of recovery.

Treatment must be approved
Treatment may not be initiated without prior approval from us. On the basis of a medical assessment, we refer to outpatient or day-care therapy at a treatment centre in Denmark designated by us.

Previous treatment
The insurance does not cover if we consider that you have previously been in treatment for the same type of addiction. Previous treatment means:

- Start of scheduled outpatient or day-care treatment at a public or private treatment centre.
- If you have been in a course of treatment with a minimum of 4 hours of weekly treatment.
- If you have been in a course of treatment, where you have received more than 25 hours of treatment.
- If you have been in antabuse treatment with your own doctor for more than 3 weeks.
- Gambling/ludomania is not covered if you have previously received psychological treatment for this.
- Other treatment, similar to the points above.

The insurance does not cover in cases of relapse to addiction during the insurance period or if you interrupt a treatment process initiated by us. We consider a course to be completed if you choose to discontinue the treatment prematurely.

The insurance premium for this cover is tax-free for the company’s employees when the need for treatment is medically certified in writing and the cover is offered to all the company’s employees. The cover does not distinguish whether the addiction is work-related or not. If the cover is not offered to all employees, the entire insurance premium for this cover is taxable for the insured party.

Cover can be provided up to a combined maximum of DKK 100,000 per insured party during the entire period of insurance, regardless of whether there are multiple addictions.

6.4 Option E Private hospital cover
This option can only be purchased as optional cover for Health Insurance Business Full-time.

The option covers reasonable and necessary examination and treatment of a coverable disease/injury carried out by a relevant medical specialist in a hospital or clinic.

We cover reasonable examinations that we consider necessary for a diagnosis, and treatment performed by the relevant medical specialist in those cases where we consider that the treatment can cure or significantly and permanently reduce the disease.

The insurance does not cover private expenses during hospitalisation or similar.

Doctor’s referral
You must always have a valid referral from your doctor. If your doctor considers that you require an examination or treatment, you will be referred to a relevant medical specialist in the public healthcare system. This referral can be used when you wish to use your insurance. Ultrasound scanning, X-ray examinations and MRI scans also require a referral.

10-day examination and treatment guarantee
You are guaranteed that a coverable examination and/or treatment will be initiated within 10 working days in the private or public healthcare system, after we have received and approved your notification. If we need more information, such as a doctor’s referral or other relevant information, the 10 working days will start after we have received and approved the necessary information. If we consider it appropriate for the treatment to be provided at a private treatment centre in our quality-assured network, this option allows you to choose to receive treatment in the private sector. We refer you to a private clinic or a private hospital in our nationwide network. You must always use the therapist we refer you to.

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

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The examination and treatment guarantee does not cover:

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

6.5 Option F Treatment of chronic disorders

The option covers reasonable and necessary treatment of osteoarthritis or other permanent disorders in the musculoskeletal system with up to 12 physiotherapy, chiropractor or massage treatments per calendar year. Of the 12 treatments per calendar year, a maximum of 4 may be physiotherapeutic massage, and a maximum of 4 treatments may be shock wave therapy performed by a physical therapist or chiropractor.

Based on a healthcare assessment, we may choose to cover extracorporeal shock wave therapy performed by a physiotherapist or chiropractor for diagnosed prolonged (more than three months) pain of tennis elbow, Achilles tendonitis, heel spur and shoulder tendinopathy where conservative treatment is unsatisfactory, or as an alternative to surgery for nonunion fractures (nonhealing bone fracture). There is no requirement for a GP referral, but the treatment must be medically justified, and we assess whether you should have a written recommendation from a doctor, chiropractor, or physiotherapist.

Preventive and relieving treatments are covered, regardless of whether the disorder occurred before or during the insurance period. Likewise, the limitation on employees with flexible or light duty jobs does not apply to this option either. You can select the healthcare provider of your own choice. If you wish, the healthcare team can help find a healthcare provider.

For extracorporeal shock wave treatment, we can decide that the treatment should take place in our network or with a therapist appointed by us. Treatment in Denmark at authorised healthcare providers is covered.

Massages must be at a registered massage therapist. Shock wave therapy must be at a licensed physiotherapist or chiropractor who uses focused shock wave equipment/focused machines.

For this option, a limit of 6 months of treatment by physiotherapist/chiropractor does not apply. Likewise, the limitation on employees with flexible or light duty jobs does not apply to this option either. The treatments are assigned in portions, and the healthcare team will continuously assess how many treatments are needed. Based on a professional assessment, we can either refuse to cover treatment of a disorder/problem in cases where we believe that the problem cannot be remedied or stop a treatment plan if the treatment is deemed to be ineffective. During the insurance period, a maximum of one approval for shock wave per problem is covered.

The treatment fee is covered; however, a maximum of DKK 465 can be covered for physiotherapy for first treatment and DKK 300 for subsequent treatments. For physiotherapeutic massages, a maximum of DKK 300 per treatment (30 minutes) can be covered. For chiropractic, the maximum amount corresponding to the deductible in accordance with the fee for regular chiropractic is covered. For shock wave treatment, a maximum of DKK 500 per treatment when the treatment is performed as a standalone treatment can be covered. When the treatment is provided as a supplementary treatment, a maximum of DKK 220 can be covered in addition to the normal treatment by a physiotherapist or chiropractor. You pay the healthcare provider yourself. Once your treatment is completed, you must submit a copy of all original bills. The bills must be submitted within three months of last treatment to be eligible for reimbursement.

Telephone-based psychological support for permanent disorders

The option covers reasonable and necessary individual telephone-based psychological counselling sessions for permanent mental health disorders, which we consider to be long-term, e.g. prolonged stress and depression, attention deficit disorders, generalised anxiety disorders, eating disorders, OCD, phobias and states of mourning as well as help for relatives of patients with serious psychiatric disorders.

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Other mental health disorders and conditions are not covered, including behaviour-adjusting treatment through a psychologist, e.g. temperament problems, infidelity, kleptomania, compulsive eating, obesity, addiction and abuse as well as couples therapy, family therapy, family conversations, coaching, self-development and expenses for medical records, certificates, psychological and cognitive tests and the like.

Treatment in our quality-assured network
The treatment must be medically justified, and the health team assesses whether you need a written medical referral or recommendation. We will refer to a therapist in our quality-assured network. The visits have a duration of approximately 30 minutes, and the required number of visits is covered based on the professional assessment of the therapist. The therapist can choose to stop a course of treatment if the treatment is deemed to be ineffectual.

There is coverage regardless of whether the illness occurred before or during the insurance period. However, for family members that are co-insured with an applicable waiting period, disorders that have arisen and/or been diagnosed before the start of the insurance will only be covered by the coverage after the end of the waiting period. Collective agreement regarding coverage of children has no waiting period. The restriction for employees employed in flexible or low-wage jobs does not apply to this coverage.

A maximum of one course can be covered per calendar year, regardless of the number of injuries/disorders. We consider the course to be completed if you choose to discontinue the treatment prematurely.

We can refuse to cover treatment of recurrent disorders/relapses if we have previously covered treatment regarding the same problem under this option.

Personal health programme for the treatment of diabetes, high blood pressure, cardiovascular disease and obesity
For diagnosed diabetes, high blood pressure, cardiovascular disease, or severe obesity (BMI of 30 and over), we can refer you to a personal digital health programme for managing lifestyle and chronic illness based on a professional assessment. You will have access to a digital behaviour modification programme that includes personal coaching, group-based interventions, and tailored health plans. The programme is offered by an experienced supplier in our quality-assured network.

The course of treatment is covered regardless of whether the illness occurred before or during the insurance period. There is no requirement for a GP referral, but the treatment must be medically justified, and we assess whether you should have a written GP referral or recommendation. A maximum of one course of treatment per illness may be covered during the insurance period. You must be 16 years or older to use the programme.

6.6 Option G Online emergency medical service
This option can only be purchased as optional coverage for company schemes. Necessary health consultations are covered by private emergency medical service for the entire household, i.e. the insured, spouse/cohabitant and the children of the household that are living at home.

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

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

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

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

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

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

The emergency medical service cannot answer questions about the health insurance, and no private referrals can be made for specialist medical practice, psychological treatment, physiotherapy, etc.

Consultations with private emergency medical services outside our network are not covered.

How to use the medical service

The emergency medical service is operated by experienced doctors on weekdays as well as weekends and holidays. It is quick and easy to use the medical service using a computer, tablet, or smartphone. You can make an appointment when it suits you or wait for a doctor to become available. You also have the option to write to the doctor 24 hours a day. During opening hours, you will receive an answer within one hour. The emergency medical service can be used in Denmark and during stays abroad.

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

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7 What the insurance does not cover

Apart from what is stated in the insurance conditions, including the provisions of the individual covers, the insurance does not cover examination, treatment and other expenses for:

- Emergency treatment and acute situations that require rapid assistance and cannot await scheduled treatment (e.g. traffic incidents, accidents, fractures, blood clots, brain haemorrhage, heart disease and other diagnosis areas that we and/or the public system define as acute and which require immediate treatment, such as life-threatening cancer and ischaemic heart disease) as well as cancer treatment packages.

- Preventative and maintenance examination and treatment, vaccinations, health examinations, health checks and other preventive controls.

- Chronic/permanent diseases that have occurred/been symptomatic and/or diagnosed before the insurance came into force. Chronic diseases and disorders that arise during the insurance periode are covered for up to 6 months from the date of diagnosis, if we consider that treatment will cause a significant and lasting improvement to the condition. Chronic diseases include chronic diseases such as type 1 and type 2 diabetes, metabolic disorders, blood disorders, hypertension, hereditary cholesterol elevation, atherosclerosis, all types of arthritis and degenerative disorders (osteoarthritis), spondylosis, bone diseases, connective tissue disorders, bunions, fallen arches, chronic pain, fibromyalgia, Scheuermann's disease, bone morbidity, chronic bronchitis, cystic fibrosis, migraine, epilepsy, Parkinson's disease, whiplash, multiple sclerosis, ALS, gastric ulcer, reflux, chronic intestinal inflammation, irritated colon, glaucoma, Ménière's disease, cholesteatoma, endometriosis, menopause problems, vaginal atrophy, hormonal disorders and similar.

- Congenital disorders and disorders that may be related to the birth/foetal stage and its consequences. This could include e.g. hip dysplasia, deformities, hip dislocation and scoliosis. Examination and treatment of asthma, leg length inequality (anisomelia) and dyspraxia are not covered.

- Diagnosing and treatment of anal fissure, anal fistulae, and pilonidal cysts.

- Cosmetic treatments and procedures and their consequences, including disorders that are considered cosmetic in these conditions, e.g. breast enlargement and reduction surgery, breast reconstruction, problems associated with cosmetic implants, face lifts, hanging eyelids (lower and upper) and gynecomastia. Treatments with Botox and Xiapex are not covered.

- Treatment or procedures for overweight/obesity as its consequences, including gastric bypass and excess skin surgery after weight loss. Psychological treatment for obesity.

- All kinds of warts, benign birthmarks and spots, lipomas, acne, eczema, psoriasis, vitiligo, rosacea, skin damage, skin transplants, actinic and seborrhoeic keratosis and similar skin disorders.

- Discomforts, infection and other effects of implants, tattoos, piercings, prostheses and similar. Complications after treatment/surgery undertaken in the public or private healthcare system. Replacement of prostheses and implants that can be performed in the public system.

- Sexually transmitted diseases, HIV/AIDS and its precursors and consequential diseases. All forms of contraception, including sterilisation, deployment and removal of IUDs (also applies to menorrhagia), and consequences of these procedures. Examination and treatment of sexual and erectile dysfunction.

- Diagnosing, examination and treatment of fertility and infertility and their consequences. This also applies to psychological consequences.

- Abortion. The insurance covers treatment by a psychologist referred by a doctor for postnatal reaction, postnatal depression and problems following abortion.

- For examinations, check-ups, scannings, and the like in connection with pregnancy and childbirth, we refer to the public sector offers. We provide counselling regarding the further process.

- Diseases in the unborn child. Colic pain and colic-like conditions in children, as well as growing pains and child incontinence.

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- Treatment and examination of ADHD with subtypes, Asperger's and disorders on the autism spectrum, dementia, Tourette's syndrome, eating disorders and their consequences.

- Treatment of severe mental illness, e.g. bipolar disorder, personality disorders, schizophrenia, psychoses, PTSD and diagnosed complicated grief. Treatment of diagnosed mental illnesses that are covered by the public treatment packages. Behaviour modification treatment by a psychologist, such as problems with temper, infidelity, kleptomania, comfort eating and addiction. Couple therapy, family therapy, coaching, self-development, supportive and maintenance conversations, as well as psychological therapy of a preventive nature are not covered.

- All kinds of phobias, such as fear of flying, fear of heights, exam anxiety and social phobia. Treatment of OCD, anxiety due to OCD and consequential conditions. Recurring instances of panic disorder, anxiety attacks and generalised anxiety are not covered.

- Couple therapy, parenting and family conversations, family therapy, coaching, self-development and similar.

- Expenses for medical records, certificates, psychological and cognitive tests, medical specialist certificates, doctor's referrals, doctor's recommendations not requested by us, participation in meetings with municipalities, schools and others.

- Cardiac arrhythmia, including radio frequency ablation (RFA), DC conversion and cardiac surgery.

- Diagnosis and treatment of sleep problems, sleep disturbances, such as sleep apnoea and treatment for snoring. Treatment at a sleep clinic.

- All types of dental treatment, dental surgery and oral surgery. Bite plates.

- Symptoms of abuse of medicine, alcohol, narcotics or other intoxicants.

- Impaired vision and hearing, including squinting, binocular vision problems, sight correction, vitrectomy, glasses, contact lenses and/or sight test, surgery for near and long-sightedness and structural defects, sight-correcting lenses in connection with surgery for cataracts, hearing-enhancing treatment, hearing aids and hearing tests.

- Treatments outside normal working hours (weekend, evening or similar supplement), as well as additional services such as shockwave, laser treatment, ultrasound, acupuncture, massage and similar. Additional expenses for soles, inserts, bandages, tape etc.

- Injuries that occur as a result of or during the performance of professional sports. Professional sport means the practice of sport, where you receive payment from a sports club or sponsors, and where the sport is practised as a primary business.

- A disease/injury that is directly or indirectly self-inflicted due to intoxication, the effects of narcotics, medicine or other intoxicants. Self-inflicted injury caused intentionally or through gross negligence, e.g. fights, attempted suicide, participation in criminal offences. Injuries caused by non-compliance with healthcare recommendations.

- Injury/disease caused by war, warlike acts and conditions, including civil war, civil unrest, rebellion, revolution, terrorism, bacteriological and chemical attacks, nuclear reactions, nuclear energy, radioactive forces, radiation from radioactive fuel and waste, epidemics and pandemics.

- Examination/treatment that is not medically justified or has no proven effect. Growth factor and orthokine treatment, PRF treatment, hyaluronic acid (injections) and modic changes. No cover is provided for experimental and alternative treatments/therapists such as natural healers, hypnotists and body therapists.

- Consultations with a general practitioner, general medicine specialist or foreign doctors that can be considered as equivalent.

- Investigation and treatment which we regard as complex and highly specialised, and which we consider can best be performed in the public health service.This could be e.g. complicated reconstructions, operation of rectus diastase, organ donation and organ transplantation, dialysis treatment, sex change operation, proton therapy and stem cell treatment.

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8 General provisions

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

8.2 Insurance sum
The insurance sum is DKK 1,000,000 per person per year. The amount is fixed and is not adjusted. If an insured person uses up the insurance sum, no further expenses will be covered. The insurance sum applies as a total maximum, regardless of whether more covers and options have been purchased.

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

We should be notified immediately if the payment address is changed. We are entitled to have any costs for postage covered. Invoicing for co-insured parties will be sent directly to the employee, unless otherwise stated in the agreement.

We charge any fees along with the payment, including costs for postage, covering our handling costs for the payment. We also charge any taxes to the state.

The due date for payment is indicated on the invoice.

Non-payment
If the insurance is not paid by the due date, we will send you a reminder with a payment deadline within 10 days after the reminder has been sent. We are entitled to charge a reminder fee.

If the insurance is not paid within 10 days after the reminder has been sent, we will send a reminder indicating that the insurance cover will expire if the insurance premium and the reminder fee have not been paid no later than 21 days after the reminder has been sent.

If the coverage expires, reported and approved claims will be finalized according to the applicable rules, cf. section 8.5 ”Termination of the insurance”.

8.4 Adjustment of premium and insurance conditions
The price is adjusted once a year, unless otherwise agreed. An annual statement is drawn up of the current number of insured persons versus the number being paid for. Any difference will be credited or charged to the policyholder.

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

Premium adjustment is not limited to changes in the net price index and/or legislative changes. If this happens, you can choose to terminate the agreement in writing from the end of the current month plus one month after the renewal premium notification has been received.

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

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

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

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

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

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8.5 Cancellation and termination of the insurance

Insurances that are purchased for one year at a time are automatically renewed from the renewal date. Unless otherwise agreed, an annual policy with annual statement of debit or credit is made.

The policyholder can cancel the insurance in writing with the current month plus one month. Dansk Sundheds-sikring can cancel the insurance in writing with the current month plus one month. In case of fraud or attempted fraud, we can terminate the insurance without notice.

The insurance terminates at the end of the month when your employment terminates, if you leave the scheme or in case of non-payment of the premium.

The insurance expires at the end of a month if you are no longer registered in National Registration Office as resident in the Nordic region or Germany. This does not apply to foreign postings.

The insurance will expire in any case at the time when the overall agreement between the company and Dansk Sundhedssikring ceases.

Coverage on termination of the insurance

When the insurance stops, you lose the right to cover and no new claims can be reported. Examination and treatment of disease/injury that has been reported and approved during the insurance period is covered for up to 3 months after the termination of the insurance. The coverage requires that we have received all the necessary information, e.g. a doctor's referral. This applies in all cases, even if the overall scheme is terminated.

Co-insured

For co-insured family members of a principal insured person who is covered by a company scheme, the insurance will continue until the date for which coverage is paid in cases where the principal insured person leaves the scheme.

Co-insured children who reach the age of 21 during the payment period are covered until the next payment period. For collective child cover, the cover for the children will always cease if the cover for the principal insured person expires or at the end of the month when the child reaches the age of 21, unless a different age applies to the contract.

Continuation of the insurance

If you are no longer covered by the company scheme, you are entitled under our rules to apply to continue the insurance on our individual conditions and individual price for private persons. Your request for continuation must be made before or in direct connection with the departure from the previous insurance contract. The continuation will then occur without a qualifying period for existing disorders. If you do not request a continuation immedia-tely, there will be a 6-month qualifying period for existing diseases in connection with a continuation. Co-insured persons can also apply for continuation of the insurance on our individual terms and individual price for private persons.

Reimbursement of invoices after termination of the insurance

Invoices for approved treatments and/or transport must always be submitted no later than 3 months after the final treatment date in order to qualify for a refund.

8.6 Disclosure obligation

You are required to provide us with the information that we find necessary in order to process the case so that we can assess the extent to which the insurance covers. We should always be notified if you change address.

We have the right to ask about your health and you are required to provide us with all relevant information, including permission to obtain necessary information from doctors, hospitals and other therapists with relevant knowledge of your health. We can obtain the informa-tion we consider necessary, including obtaining medical records or other written material about your health. We always only collect information with your consent. The information concerns both the period before and after the insurance's entry into force.

We should always be notified if you change address. Membership of Sygeforsikringen "danmark" must always be disclosed in connection with the creation of a claim, as we are entitled to receive this subsidy.

A co-insured spouse/cohabitant is obliged to inform us if they are divorced or leave the employee who is covered by the scheme.

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When you leave your position
When reporting a disease/injury, or if you request treatment, you are required to inform us if you have left or will leave the company. The insurance covers approved claims that have been reported during the insurance period for up to 3 months from the date you leave the company. We may require a refund of costs for examination or treatment if you have failed to inform us that you have left the company and have received more than 3 months of treatment.

Double insurance
If changes are made to the insurance policy's risk condition, including double insurance, we must be immediately notified of this, as we may otherwise limit the cover or completely refuse to cover the claim. If you have made a claim to another insurance policy, you must always inform us of this in connection with making a claim to us. If there is cover from another insurance company, the cover from this insurance will be secondary and the other cover should therefore be used first. We do not pay costs for claims for which cover has been received from another company.

8.7 Processing of personal information
We treat your personal information confidentially and in accordance with applicable legislation. When you purchase insurance from us, we gather information in connection with enrolment, filing a claim and use of our digital platforms, e.g. civil registration number, telephone number, e-mail address, 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 in case of a claim and in the ongoing case processing to ensure the best possible service and as part of sales management, product development, quality assurance, advice and determination of general user behaviour.

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

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

8.8 Processing of health information
There is no requirement to provide health information when you take out insurance with us. If you wish to enter the scheme after having previously provided a waiver statement, however, we may require you to provide necessary health information. When reporting a disease/injury, you accept that we may obtain information about your health if we consider it to be relevant in connection with the reported disease/injury. We can obtain the information from the public healthcare service, public authorities, including municipalities, the National Board of Industrial Injuries, insurance companies, pension companies, Sundhed.dk etc. Information is always obtained with your written or oral consent.

Health information is only used in connection with the handling of the reported disease/injury and is always handled in accordance with the requirements of the Health Act regarding confidentiality (§40 of the Health Act: "a patient is entitled to healthcare professionals observing confidentiality about what they learn or suspect during the performance of their duties regarding health matters, other purely private and other confidential information").

The disclosure of health information occurs solely in connection with the examination/treatment of the reported disease/injury in accordance with §41 of the Health Act regarding the 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 conceal information when the insurance policy is created or later, the right to cover may lapse in whole or in part.

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

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8.11 Avenues of complaint

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

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

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

If you then wish to appeal the decision taken by the complaints manager, you may appeal to the Insurance Complaint Board. There is a fee for appeals to the complaint board, and the complaint must be submitted on a special complaint form, which you can obtain from the complaints board.
The address is as follows:

Ankenævnet for Forsikring
Østergade 18, 2nd floor
1100 Copenhagen K
Telephone +45 33 15 89 00 between 10.00 AM and 1.00 PM
www.ankeforsikring.dk

Applicable law

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

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

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

8.12 For further information

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