



Terms - Trade and Industry

Health Insurance

Leisure-related coverage

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1 Basis for the agreement

These insurance conditions are valid from 1 January 2024.

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

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

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.

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.

1.2.1 The disease/injury must be leisure-related

It is a prerequisite for coverage that the disease, injury or disorder is directly leisure-related. This means that there must be a direct causal link between leisure and the reported claim. The insurance does not cover determination of whether the claim is leisure-related. If there is any doubt about whether the claim is leisure-related, the insurance will not cover. We may require that your medical referral, medical records or similar indicate that the reported claim is not caused by your work.

If the cause of the claim is work-related, there is no cover in this insurance policy.

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.

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 notify us on an ongoing basis of the employees who wish to subscribe to or unsubscribe from the insurance plan. You can only subscribe and unsubscribe during the current year and no more than 3 months in arrears. Adjustments at the time of annual renewal, which trigger a new invoice, may be subject to an administration fee.

The company pays for claims payments that Dansk Sundhedssikring has made for employees who have been 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 24th 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 24. 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 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.

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.

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.

4.7.1 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 normally 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.

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 our website: ds-sundhed.dk

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 (Health Navigator) and health professional advice

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

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

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

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

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

In cases where the injury can only be handled in the public sector or is not covered by the insurance, we offer

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.

to provide you with advice regarding your course of treatment in the public health service.

5.2 Pregnancy counselling

The health insurance offers telephone counselling sessions for pregnant women and new parents by a personal pregnancy counsellor. Our pregnancy counsellors all have relevant health backgrounds, such as nurses with experience from neonatal and maternity units, and offer telephone counselling on topics such as pregnancy symptoms, pregnancy at work, the first postnatal period, parenting, abortion, diet, lifestyle, working life, childbirth, relationships, postnatal reactions, postnatal depression, maternity and breastfeeding counselling, and child well-being and development. Based on the dialogue with you, the pregnancy counsellor will assess whether a follow-up interview is needed.

You can call for advice every weekday between 9 am and 4 pm at +45 70206121. If a pregnancy counsellor is not available, you will be called at an agreed upon time.

5.3 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.

5.4 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.

5.5 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.

5.6 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. Special provisions apply to medical specialists in psychiatry in accordance with section 5.8 "Mental health".

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.

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.

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.

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.

Cataracts

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.

Varicose veins

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

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.

Examination and treatment abroad – Cancer Care

For the Cancer Care cover, please see Appendix 1: Personalised medicine and cancer treatment abroad. You are covered by Cancer Care if it is stated in the insurance contract.

In the event of disagreement about the choice of treatment/treatment plan and where the treatment can be carried out in the home country, the treating specialist in

the home country always decides which treatment can be offered. Treatment will take place in the home country.

If there is any discrepancy between the Danish and English versions of Appendix 1, the English text always takes precedence. The English supplement can be found on our website: ds-sundhed.dk.

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.

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.

5.6.1 Follow-up examinations

The insurance covers the necessary outpatient follow-up examination after coverable surgery for up to 24 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.

5.6.2 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.

5.6.3 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).

5.6.4 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 24 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.

5.6.5 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. 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.

5.6.6 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 therapist of your choice based on a professional assessment. 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.

5.6.7 Recuperation

The insurance covers the costs of an approved recuperation stay in Denmark directly following surgery or hospitalization covered by the insurance. Reasonable and necessary expenses are covered, upto a maximum of DKK 65,000.

The stay must be prescribed in writing by the attending specialist and Dansk Sundhedssikring's doctor. We may make a request for a submission of a treatment plan. We will refer you to a treatment centre in our quality assured network.

There is no subsidy for holiday-like stays, relaxation, or the like. Recuperation stays due to mental disorders are not covered. A maximum of DKK 65,000 per insured person can be covered for recuperation stays throughout the period of insurance.

5.6.8 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.

5.6.9 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 taxis 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.

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.

5.7 Physical health

Already upon your first contact with the insurance company, the healthcare team can offer counselling and support for dealing with physical challenges – regardless of whether the insurance covers them.

To ensure optimal prevention, counselling and treatment of your problem, we may, based on a professional assessment, refer you to various forms of counselling and treatment and/or self-training, such as training counselling,

training videos, training app, online physiotherapy, physiotherapy and chiropractic with physical attendance or a combination of digital treatment and physical attendance.

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

Training app

Based on a medical assessment, we can give you up to 6 months' access to a training app that offers rehabilitation and prevention of pain in the entire body based on specially designed training programmes.

Physiotherapist and chiropractor

The insurance covers reasonable and necessary treatment 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.

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. 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.

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

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 treat-

ment 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.

Online physiotherapy

If you are treated by a physiotherapist, we can refer you to an online course of treatment with physiotherapists with whom we have a partnership. The course of treatment includes video consultations with the physiotherapist, independent training, guidance and ongoing follow-up with the physiotherapist via video and chat functions and subsequent access to a digital training platform.

GLA:D training for hip, knee and back

If you are diagnosed with hip or knee osteoarthritis, long-term (more than 3 months) or recurring back pain, we may choose based on a professional evaluation to cover a GLA:D training plan. The healthcare team can refer directly to 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 length of the treatment plan depends on a professional assessment and is based on the Danish Health Authority's guidelines for GLA:D treatment plans. The treatment can take place in our network or with a therapist of your choice.

For GLA:D training, a limit of 6 months of treatment from the time of diagnosis does not apply.

Cover is provided for the therapist's fee up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the agreement's index-adjusted rates.

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.

Treatment in Sweden, Norway and Germany

If you reside in Sweden, Norway or Germany, 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 Mental health

Already upon your first contact with the insurance company, the healthcare team can, based on a professional assessment, offer counselling and support for dealing with mental challenges – regardless of whether the insurance covers them.

In cases where we assess that you need treatment, for example, if you have reduced ability to function in everyday life and symptoms that require treatment, the insurance covers reasonable and necessary treatment in Denmark. It is a prerequisite for coverage that the damage is eligible for coverage.

We can offer counselling for challenges with stress, well-being and life changes and refer to various treatment options, including telephone, online or face-to-face treatment, as well as a specialised treatment product for children. The type of course of treatment will depend on the individual case and the health team's professional assessment. The detailed provisions are presented in the individual sections.

In cases where our healthcare professionals believe that assessment and/or treatment can best be carried out in the public sector, we can refer to public services to be activated and used. This may be the case, for example, when there is no lasting improvement after previous attempts at treatment with a psychologist and/or psychiatrist, or if it is a recurring disorder. We offer guidance and support throughout the process.

If you are referred for a treatment package in the public healthcare system, this offer must always be used.

Crisis prevention and support helpline

With a health insurance policy at Dansk Sundhedssikring, you can call and get personal advice 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 relevant professional background within health and can help you prevent and manage problems before they become major issues.

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

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

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

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

Support line for managers

The support line for managers is an offer for HR and managers and provides access to telephone counselling, where you as a manager can get help to explore new perspectives or examine your options for action, if you e.g. have employees with stress, employees with private challenges that affect work, wellness issues, bullying, conflicts, or if there has been an accident or a violent incident at the workplace.

The support line for managers is handled by our internal team for mental health, all of whom have relevant professional backgrounds. Based on the dialogue with you, the mental health team will assess whether a follow-up interview is needed.

Based on a professional assessment, the mental health team can refer to a quality-assured and experienced occupational psychologist.

You can call the support line for managers every weekday between 9 am and 4 pm. You enter the line via the menu when you call our main number +45 7020 6121.

Free access to a mental health app and mindfulness for children, youth and parents

We can give you six months of access to a mental health app based on a medical assessment. The app is based on cognitive behavioural therapy and teaches children between the ages of 8 and 16 and their parents to deal with difficult emotions and topics such as grief, bullying,

shyness, divorce, social anxiety, sleep problems, addiction to gaming, and mindfulness for children and adults.

Digital ADHD/ADD counselling by a psychiatrist and a specially trained psychologist

You get access to a digital learning platform with self-help in the form of useful knowledge and guidance on ADHD/ADD. The platform that relatives also can use has been prepared by specialists in psychiatry and psychology. You must be 18 years or older to use the platform.

The mental toolbox

We offer various health-promoting initiatives in the form of online courses if you feel that your mental well-being is affected, but you don't need actual therapy. You will gain knowledge about the healthy mind's reactions to stress and get concrete tools to take action and safeguard your mental health. We can offer access to various targeted programmes based on a healthcare assessment:

- **Mental health – your toolbox**
Course with a health-promoting focus for customers with life challenges who need tools to take action to improve their mental health. You gain knowledge about the reactions of the mind and get concrete tools that you can use in the future to safeguard your mental health.
- **Mental health – your toolbox with a mentor**
Personalised conversations with an experienced mentor for life challenges who need additional support to work with tools to improve your mental health.
- **Mental health – your toolbox as a manager/HR**
Courses targeted at managers and HR with a focus on healthy reactions to life challenges and how a manager/HR can support employees with common challenges faced by people.

Therapy with a psychologist and psychotherapist

Based on a professional assessment, the insurance covers relevant, reasonable and necessary individual treatment/therapy with an authorised psychologist (auto.cand. psych.) in our network, with a psychologist of your choice or with a quality-assured psychotherapist in our network.

The healthcare team will refer you to the treatment programme and will continuously assess how many treatments you need and whether you are receiving the right treatment.

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

We assess whether you must submit a doctor's referral or recommendation.

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. Based on a professional assessment, we can recommend different forms of treatment:

- **Course of therapy by telephone**
We can refer you to a course of therapy by telephone provided experienced psychologists and psychotherapists.
- **Online course of therapy**
We can refer to video consultations with experienced psychotherapists and psychologists. As part of the course of therapy, you get access to an online library of exercises and information on mental health.
- **Online stress management plan**
All courses of therapy are tailored to the individual and may include access to materials, online coaching and/or an online or physical programme.
- **In-person therapy sessions**
We can refer you to in-person therapy sessions with experienced psychotherapists and psychologists.
- **Specialised treatment product for children with mental health problems**
We can refer to specially designed treatment programmes for children under 15 years of age and their parents. The programmes are run by psychologists with specialised experience in the field and involve parents to a large extent in the treatment. Involving parents increases their contribution to the therapeutic alliance and strengthens their ability to help the child - even after treatment has ended. In certain cases, a written handover of relevant information may occur and be shared with e.g. the municipality, pedagogic-psychological counselling, school, psychiatry or caseworker so that they are able to provide the appropriate support.
- **Dialogue for work-related stress**
For work-related stress, we can refer you to a tripar-

tite course of treatment between you, your manager (or HR) and a psychologist based on a professional assessment and in consultation with you. We will find you a psychologist who is specialised within stress and stress management in the workplace. The course of treatment focuses on the labour market situation, for instance, when there is a need for help with maintaining or returning to the workplace. The course of treatment 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.

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 more treatments are needed, 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.

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.

The length of the therapy 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, Norway and Germany

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

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. It is a prerequisite for coverage that the disorder is eligible for coverage.

The consultations are allocated in portions and we refer to a therapist. You can also choose which psychiatrist to use. The insurance covers the therapist's rate up to a maximum of DKK 2,000 per treatment.

5.8.1 Trauma counselling

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

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

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

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

If we consider that you need emergency trauma counselling, we will find a psychologist for you in our network. You will have telephone contact with the psychologist within 3 hours after the notification is approved. The subsequent process will depend on the nature of the incident and the therapist's professional assessment.

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

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

Based on a professional assessment, we can choose to cover debriefing in the form of one session with a psychologist at the workplace if there has been a serious work accident or a violent/traumatic incident involving several employees or the witnessing of such an incident and needing help.

Debriefing is not covered for anticipated incidents, dismissals, conflicts and the like.

An option for the purchase of additional debriefing sessions for groups is provided. For purchases, the initiative is coordinated with the workplace.

Emergency psychological counselling or debriefing abroad is 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.

5.10 Dental treatment

The insurance covers dental treatment prescribed by a specialist when there has been an injury to the teeth in direct connection with the treatment of an injury that is eligible for coverage where we have initiated the treatment. Reasonable and necessary expenses of up to DKK 20,000 per claim are covered.

5.11 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 personalised programme of digital health coaching, counselling and tailored health plans from an experienced clinical dietitian. Based on a professional assessment, the programme can be combined with digital personal counselling with a psychologist, physiotherapist and/or a specialist doctor. 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. 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 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, authorised osteopath 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.

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 disease, gout, celiac disease, PCO/PCOS, metabolic disease requiring treatment are diagnosed during the insurance period, or if underweight requiring treatment is medically assessed as posing a risk to your health, 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 dietitian for severe obesity during pregnancy as well as postpartum weight that requires treatment.

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 therapist's fee will be covered up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the agreement's index-adjusted rates.

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).

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 daycare 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 daycare 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 and you have received conversational therapy at the same time.
- 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.

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.

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 diagnosed or long-lasting (more than 6 months) osteoarthritis or other chronic 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. 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. 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 amount corresponding to the full fee for general physiotherapy, cf. the agreement's index-adjusted rates. 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 (ADHD/ADD and subtypes), autism spectrum disorders, Tourette syndrome, generalised anxiety disorders, eating disorders, OCD, phobias and states of mourning/prolonged grief disorder as well as help for relatives of patients with serious psychiatric disorders.

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.

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.

Podiatry

The option covers treatment by a podiatrist if you have a referral from your doctor because of diabetes, arthritis, ingrown nails, or scar tissue after radiation therapy. Up to 6 treatments per calendar year are covered, regardless of whether the disorder occurred prior to or during the period of insurance. For diabetes, one annual foot check is covered.

You can use a practitioner of your choice. However, you must have a valid doctor's referral for podiatry, and the treatment must be carried out in Denmark by a state-authorized podiatrist with an agreement with the national health service/regions (provider number).

The amount corresponding to the co-payment (patient share) is covered after national health service subsidies according to the collective agreement's rates for podiatrists. The insurance does not cover distance allowances, mileage reimbursement, insoles, adjustment of insoles, and the like.

6.6 Option G Online emergency medical service

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

Online emergency medical service is a supplement to your general practitioner and offers quick access to

email and video consultations with a private emergency 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.

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.

6.7 Option H Extended psychiatric assessment

This option covers reasonable and necessary expenses for initial examination, assessment and diagnosis of ADHD/ADD and/or autism spectrum disorders.

It is a prerequisite for coverage that you have a referral from a doctor.

Expenses are covered for one course of investigation per insured party, including combined assessment for ADHD/ADD and autism spectrum disorders. The duration and content of the course of investigation depend on the therapist's professional assessment. The investigation must be carried out during the insurance period. The insurance does not cover a new investigation and/or a second opinion in cases where a diagnosis has previously been made.

We refer you to a treatment centre with which we collaborate.

In cases where we have an investigation under coverage and where a diagnosis of ADHD/ADD and/or autism spectrum disorders has been made, we cover subsequent medication follow-up – and adjustment for up to 6 months. Therapy and/or group counselling after a diagnosis has been made is not covered.

The limit of one course of investigation also applies if you resume an insurance relationship or take out a new insurance policy with Dansk Sundhedssikring.

For option H "Extended psychiatric assessment", the full insurance terms and conditions apply, but with the detailed rules and exceptions mentioned above.

6.8 Option K Surgery for chronic musculoskeletal disorders

With this option, reasonable and necessary initial examinations and surgery for chronic disorders of the musculoskeletal system are covered if it is assessed that this can cure or significantly and permanently improve the condition. You must always have a valid referral from your doctor.

Surgery is covered for chronic musculoskeletal disorders diagnosed during the insurance period - beyond six months from the time of diagnosis. However, ongoing and planned treatment is not covered.

Surgery for chronic disorders of the musculoskeletal system that were diagnosed before the insurance came into force is covered. However, ongoing and planned treatment is not covered.

The surgery must always be performed during the insurance period.

In relevant cases, we will cover expenses for therapeutic blockade treatment of chronic musculoskeletal disorders performed by a relevant specialist appointed by us in cases where we assess that the blockade treatment can significantly and permanently improve the condition. Up to 3 blockades per condition are covered during the insurance period.

We cover necessary outpatient follow-up care after a covered surgery for a chronic musculoskeletal disorder for up to 24 months from the date of surgery, if the surgery was performed at a treatment centre designated by us. Examinations must be carried out during the insurance period. Repeat check-ups are not covered.

One re-operation following a covered surgery for a chronic musculoskeletal condition is covered if the primary surgery was 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.

In cases where the primary surgery is not performed at a treatment centre designated by us, the insurance covers one re-operation. Re-operation is not covered in cases where the primary surgery was performed in the public healthcare system or in the private healthcare system paid for by the public sector.

The insurance does not cover examination and treatment/surgery of chronic musculoskeletal disorders, which we

consider to be complicated and highly specialised and which, in our opinion, are best performed in the public healthcare system.

Rehabilitation after a covered surgery for a chronic musculoskeletal disorder is covered according to the provisions in the section "Rehabilitation after surgery".

The insurance does not cover examination and treatment/surgery of congenital disorders and disorders that can be related to the birth/foetal stage and their consequences,

including hip dysplasia, deformities and scoliosis. Reconstructions, amputations, transplants, replacement of prostheses and the like, as well as examination and treatment of leg length discrepancy are not covered.

For surgery for chronic musculoskeletal disorders, the full insurance terms and conditions apply, including the section "Option E Private hospital cover" and the section "What the insurance does not cover", but with the detailed rules and exceptions mentioned above.

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 period 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. tongue-tie, 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, Xiapex and treatment of sweating 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 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.
- Treatment and examination of ADHD with subtypes, Asperger's and disorders on the autism spectrum, dementia, Tourette's syndrome, eating disorders and their consequences. Examination and treatment of gender dysphoria.
- Treatment of severe mental illness, e.g. bipolar disorder, personality disorders, schizophrenia, psychoses, PTSD and diagnosed complicated grief. Treatment of diagnosed mental illnesses that are covered by the public treatment packages.
- Consultations at a neuropsychologist.
- Conversational therapy and expenses for medicine at psychiatrists.
- Behaviour modification treatment by a psychologist, such as problems with temper, infidelity, kleptomania, comfort eating and addiction.
- Couple therapy, family therapy, parenting and family conversations, coaching, self-development and similar, 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 and exam anxiety. 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.
- 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 and bite plates (dental treatment is covered based on the special provisions for 5.10 Dental coverage).
- 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, pandemics, viral infections and related vaccines.
- Examination/treatment that is not medically justified or has no proven effect.
- Experimental and alternative treatments/therapists such as natural healers, hypnotists, and body therapists.
- Growth factor and orthokine treatment, PRF treatment, hyaluronic acid (injections) and modic changes.
- 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, organ donation and organ transplantation, dialysis treatment, sex change operation, proton therapy and stem cell treatment.

8 General provisions

Communication

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

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

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.

Monthly payment

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

Timely payment date

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

Overdue payment

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

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

Fee for services

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

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

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

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.

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 Sundhedssikring 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 24 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 24, 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 immediately, 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 information we consider necessary, including obtaining medical records or other written material about your health. We always only collect information with your consent. The information concerns both the period before and after the insurance'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.

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.

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. You must send your complaint online at ankeforsikring.dk. There is a fee for appeals to the complaint board.

Applicable law

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

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

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

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.