DANSK SUNDHEDS SIKRING

Conditions - private

Health Insurance Senior

Version 2.1 | Forsikringsselskabet Dansk Sundhedssikring A/S | Q1 | 2024

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1. Contractual basis

These insurance conditions are valid from 1 June 2024.

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

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

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

The policyholder receives information from Dansk Sundhedssikring about the insurance and how it is used. Definitions of the individual terms used in the insurance conditions:

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

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

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

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

1.1 When does the insurance apply?

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

1.2 What does the insurance cover?

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

2. Who is covered by the insurance?

The insurance can be taken out by private individuals who have reached the age of 60 and are under the age of 75. The insured must have a permanent registered address in Denmark (excluding Greenland and the Faroe Islands), have a Danish health card and be entitled to receive Denmark's public health insurance benefits.

2.1 Co-insured

It is possible to co-insure your spouse/partner at a separate price. Your spouse/partner can be insured from the age of 60 and until the age of 75.

Your spouse/partner must have a permanent registered address in Denmark (excluding Greenland and the Faroe Islands), have a Danish health card and be entitled to receive Denmark's public health insurance benefits.

2.2 Waiting period provisions

The waiting period depends on whether you already have health insurance with us.

- If you already have another active health insurance with us – and take out Sundhedsforsikring Senior as a direct extension of your existing insurance – there is no waiting period for existing diseases, injuries and conditions.
- If you do not have health insurance with us, there is a six-month waiting period for existing diseases, injuries and conditions. This means that you must have been covered by this insurance for six months before expenses are covered for examination and treatment of conditions that have arisen and/or been diagnosed before the insurance took effect.

Diseases and injuries that occur after the insurance takes effect are covered in accordance with the applicable insurance conditions.

3. Where does the insurance cover?

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

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

4. Use of the insurance

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

4.1 Doctor's referral

Unless otherwise stated in the individual cover, you must have a doctor's referral or re-commendation describing the disease/injury before using the insurance. The doctor's referral must be available before any examination or treatment can begin. You should there¬fore start by consulting your GP, who can best assess your treatment needs. If your GP assesses that you need examination or treatment, you should, if possible, be referred for treatment in the public healthcare system. You can use this referral when you report the claim to us.

4.2 Examination and treatment must be approved

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

4.3 Emergency treatment is not covered

Emergency treatment and emergency situations are not covered by the insurance, including examinations and treatment that require urgent assistance and cannot wait for planned treatment. This applies, for example, to traffic accidents, fall injuries, accidents, fractures, blood clots, cerebral haemorrhage, heart disease and other diagnostic areas that we and/or the public authorities define as acute, including cancer treatment packages, life-threatening cancer and ischaemic heart disease. If you need emergency assistance, including an accident and emergency unit or ambulance, you must always contact your GP, the emergency medical service, the emergency telephone line, the accident and emergency unit or 112. The insurance covers the expenses for psychological counselling in the event of a need for emergency crisis help.

4.4 Travelling and staying abroad

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

4.5 Absence from treatment

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

4.6 Ongoing and planned treatment

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

4.7 Expenses for treatments

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

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

In cases where we refer you for examination or treatment at a private clinic or private hospital, payment will normally be made directly between the treatment centre and us.

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

4.7.1 Rates for physiotherapy, chiropractic and psychological treatment

For physiotherapy, the therapist's fee is covered, up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the indexed rates in the collective agreement. For chiropractic care, the amount corresponding to the patient share is covered at the rate that applies to general chiropractic care. Psychological therapy takes place in our quality-assured network, and we settle with the therapist. Other treatment rates are stated in the individual covers.

4.8 Choice of therapist

In our judgement, the treatment must be expected to cure the disorder or significantly and permanently improve the patient's health.

Only treatments that are authorised by the public health authorities in Denmark and in accordance with national clinical guidelines and commonly used in the public healthcare system are covered. The treatments must be carried out using methods with documented effect and be included in the agreement with the National Health Service.

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

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

For physiotherapy and chiropractic care, we typically recommend treatment in our quality-assured national network. However, you have the option to choose a therapist of your own choice. For treatment in our network, we endeavour to start your treatment within four or five working days and a maximum of ten working days.

Psychological therapy takes place in our quality-assured network.

For examination and treatment by a specialist, the first examination and/or treatment will be initiated within 15 working days in the public or private healthcare system. We refer you to a clinic. The 15 working days do not apply to specialists in psychiatry (psychiatrists) or when assessing osteoporosis.

The treatment method must always be authorised by us.

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

4.9 Assessment of treatment needs

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

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

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

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

4.10 Reporting a claim

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

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

Emergency crisis counselling

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

5. What does the insurance cover?

This section contains the various types of basic cover. The full insurance conditions apply to all sections, but with the special rules and exclusions that apply to each individual cover.

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

5.1 Health Navigator and health counselling

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

You are offered telephone consultations with nurses, physiotherapists and doctors for all health and medical problems – even those that do not require actual treatment or are not covered by the insurance. The health team can provide advice on health and well-being, welfare issues, stress and stress prevention, substance abuse issues, pain, pregnancy, courses of treatment and management challenges.

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

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

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

5.2 Chronic diseases

The insurance covers examination and treatment by a specialist of chronic diseases and conditions that occur during the insurance period, for up to six months from the date of diagnosis, if we assess that treatment will lead to a significant and lasting improvement of the condition.

Chronic musculoskeletal disorders that have occurred during the insurance period are covered for physiotherapy and chiropractic care beyond six months from the time of diagnosis.

Chronic diseases and disorders of the musculoskeletal system that have occurred and/or been diagnosed before the insurance period are covered with physiotherapy and chiropractic care once the applicable waiting period has expired, see section 2.2 "Waiting period provisions".

Other chronic conditions and diseases occurring and/or diagnosed before the insurance period are not covered.

We define chronic diseases as illnesses, conditions and disorders that our doctors deem to be persistent, which are incurable, and for which there is no curative treatment.

The healthcare team always offers help for all chronic conditions with advice and guidance on the public healthcare system's treatment options, patient rights, waiting times, assessment and treatment guarantees and help with appointments in the public healthcare system.

5.3 Complications of chronic diseases

Examination and treatment of complications that occur during the insurance period as a direct consequence of a chronic disease are covered for up to six months from the date of diagnosis. It is a prerequisite for cover that we assess that treatment will lead to a significant and lasting improvement of the condition. Complications that occurred before the insurance came into force are not covered.

5.4 Pain assessment

Assessment and treatment of long-term pain problems at e.g. a pain clinic or headache clinic as well as pain treatment in connection with cancer are not covered by the insurance. The healthcare team helps with counselling in the further process.

5.5 Examination and treatment by a specialist

The insurance covers reasonable and necessary examination and treatment of a covered disease/injury performed by a relevant specialist at a hospital or clinic. Special provisions apply to specialised psychiatrists, cf. section 5.8 "Mental health".

Reasonable examinations that we consider necessary to make a diagnosis and treatment performed by a relevant specialist are covered in 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 GP assesses that you need examination or treatment, you will be referred to a relevant specialist in the public healthcare system. You can use this referral when you want to use your insurance. Ultrasound scans, X-rays and MRI scans also require a referral.

Examination and treatment guarantee

You are guaranteed that a covered examination and/or treatment by a specialist is initiated in the private or public healthcare system within 15 working days after we have received and approved your claim.

If we need more information, such as a doctor's referral or other relevant information, the 15 working days will start after we have received and approved the necessary information.

If we assess that it is not possible for you to get an appointment within 15 working days in the public healthcare system – including free choice of hospital and activation of the right to rapid assessment and treatment – we can 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 to which we refer you.

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

We can at any time request medical records, referrals or certificates that we deem necessary for our medical assessment, including whether the reported condition is 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 15 working days, but the date does not suit you, for whatever reason.
- If you completely or partially reject an offer of examination and/or treatment in the private or public healthcare system, e.g. because you want a different treatment centre than the one indicated.
- If you express a wish for treatment at a later date than during the period of the examination and treatment guarantee.
- If we assess that it is not medically appropriate to initiate an examination or treatment within 15 working days.
- If an authorised and scheduled examination or treatment is postponed for medical reasons.
- If we assess that the treatment is highly specialised and should be carried out in the public sector, e.g. in the case of special disease diagnoses, complicated disease developments, or if you are undergoing a long-term assessment process in the public sector.
- In the event of major conflicts and/or limited capacity in the public healthcare system, as well as unforeseeable events beyond our control – in these cases we are entitled to a reasonable extension of the guarantee.

Skin conditions
The insurance covers skin conditions that we deem to affect your state of health. Skin conditions that we consider cosmetic or chronic are not covered. These include benign moles and spots, acne, eczema, all types of warts, corns and sun damage to the skin. Recurring skin conditions or relapses, e.g. elsewhere on the body, are not covered. We are always happy to provide counselling, navigation in the public system and appointment assistance for all skin conditions.

Skin cancer (basal cell carcinoma)
If we have covered treatment for skin cancer (basal cell carcinoma), the insurance will not cover if the disease returns and requires a new examination and/or treatment. The insurance does not cover treatment with Mohs surgery or similar types of treatment.

Allergy testing
The insurance covers allergy testing for the purpose of making a diagnosis. The test must be prescribed in writing by a doctor and authorised by us. If you have previously been examined for the same allergy, a new examination is not covered.

Cataracts
Cataracts diagnosed during the insurance period, including the development of secondary cataracts, are covered for up to six months from the date of diagnosis. Treatment and surgery are covered based on the Danish Health Authority's current guidelines, which are used in the public healthcare system for the treatment of age-related cataracts.

Secondary cataracts are considered a sequela and are covered for up to six months from the date of diagnosis. Cataracts and secondary cataracts diagnosed before the insurance came into force are not covered.

Varicose veins
Varicose veins are only covered if, in our judgement, there are serious symptoms, such as loss of driving licence, sick leave or deep inflammation.

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

Excluded from cover are cancers that require complicated treatment methods, such as chemotherapy and radiotherapy, as well as emergency or experimental treatment.

Treatment is only covered if it is performed at private hospitals in Denmark with which we cooperate. In case of cancer diseases that form part of a comprehensive treatment package in the public healthcare system, the public service must always be activated and used. The healthcare team helps with counselling in the further process.

Heart diseases
For treatment/surgery for heart disease, we refer you to the public healthcare services, as we consider it an emergency treatment. We help with counselling in the further process.

Osteoporosis
The insurance covers – in relevant cases – assessment for osteoporosis and one possible injection with a biological drug if this has been prescribed by a specialist. Additional treatment or other forms of medical treatment are not covered. The healthcare team can advise you on public treatment options.

The treatment guarantee of 15 working days does not apply to the assessment of osteoporosis. The healthcare team can help you find a private or public healthcare appointment.

Addiction counselling
If you have a substance abuse problem, such as alcohol, medication or drugs, you can call our healthcare team for counselling. The healthcare team can also guide you to public treatment programmes.

5.6. Follow-up checks

The insurance covers necessary outpatient follow-up after covered surgery performed through us for up to 24 months after the last day of treatment, provided that the insurance is still active. The check-up must be prescribed by a relevant specialist and, in our judgement, be reasonable and necessary. The insurance does not cover repeated check-ups.

5.6.1 Re-operation

The insurance covers a re-operation after a covered operation if the primary operation was performed at a treatment centre designated by us and there are no medical reasons why a re-operation is not recommended.

The re-operation must be prescribed by a specialist and approved by Dansk Sundhedssikring's doctor. We will refer you to a treatment centre.

5.6.2 Second opinion

In certain cases, the insurance covers consultation with a relevant specialist if you:

- Have a life-threatening or particularly serious disease or injury.
- Are faced with the choice of receiving particularly risky treatment that may be life-threatening or cause permanent injury.

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

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

5.6.3 Medical expenses

The insurance covers reasonable out-of-pocket expenses for prescription medication in direct connection with a covered surgery at a treatment centre designated by us. The medication must be prescribed by the attending specialist and be necessary for the surgery performed. Medical expenses are covered for up to 24 months from the date of surgery. Expenses for over-the-counter medication are not covered. This also applies if the medicine is available both on prescription and over the counter.

5.6.4 Temporary assistive devices

The insurance covers reasonable expenses for personal temporary assistive devices that we deem necessary in connection with a covered operation at a treatment centre designated by us. The assistive device must be prescribed by the attending specialist. Expenses for assistive devices for outpatient rehabilitation are not covered.

Expenses for assistive devices that can be received through public subsidies for assistive devices are not covered. Orthopaedic footwear, CPM machines and the like are not covered.

5.6.5 Rehabilitation after surgery

The insurance covers outpatient rehabilitation with a physiotherapist in direct connection with a coverable operation on the musculoskeletal system. The surgery must have been performed at a treatment centre designated by us. The musculoskeletal system is defined as tendons, muscles and joints in the back, shoulders, neck, knees, hips, elbows and wrists. The rehabilitation must be prescribed by the attending specialist, and you must always have a valid referral for physiotherapy from the specialist. Convalescence and treatment stays are not covered.

Rehabilitation will always take place in our quality-assured network. One course of rehabilitation is covered per covered musculoskeletal surgery. The course of rehabilitation can – after a professional assessment – last for a maximum of six months.

5.6.6 Home help/home nurse

The insurance covers reasonable and necessary expenses for temporary help at home in direct continuation of a covered operation initiated by us. As a necessary part of the treatment, the help must be prescribed by the attending specialist. Temporary help with cleaning, shopping, personal hygiene, dressing and undressing is covered for a maximum of three months from the date of discharge and for a maximum of DKK 30,000 in the insurance period.

Home help is not covered in cases where the need can be attributed to old age, dementia, senility or similar. We may choose to have the service provided by a home care service provider designated by us.

5.6.7 Transport expenses

The insurance covers reasonable transport expenses in Denmark between home and the treatment centre in connection with specialised medical care at a hospital/clinic. The transport must always be agreed with and authorised by us. Transport expenses to a specialist in psychiatry are not covered for emergency crisis counselling. Taxi fares are not covered.

Transport bills must be submitted no later than three months after the treatment has been completed in order for you to be eligible for reimbursement.

Transport to and from examination/treatment

The insurance covers transport expenses to and from a covered examination/treatment by a specialist in cases where we refer you to a hospital or clinic more than 75 kilometres from your place of residence. Cover is provided at the state's lowest rate for driving your own car or for the cheapest form of public transport.

Patient transport (recumbent)

The insurance covers recumbent patient transport between home and hospitalisation/operation at a treatment centre designated by us. Recumbent transport must be prescribed by the attending specialist. It is a prerequisite for cover that we assess that, for health reasons, you cannot be transported by car – even as a passenger – or by public transport, and that the transport is not covered elsewhere. We may choose to arrange transport with a supplier designated by us.

Medical escort

The insurance covers reasonable transport costs for one medical escort if we deem that your medical condition requires the presence of an escort.

5.7 Physical health

The insurance covers reasonable and necessary treatment by a physiotherapist and chiropractor in Denmark following a referral from the healthcare team. It is a prerequisite for cover that there is a medically documented need for treatment and that the treatment ensures progression/improvement of the condition. A maximum of ten treatments per calendar year can be covered, regardless of the number of injuries/conditions.

Physiotherapy

Based on a professional assessment, the healthcare team will refer you to physiotherapy either in our quality-assured network or to a therapist of your choice. The healthcare team will assess whether you need a medical assessment/medical referral in relevant cases. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments.

GLA:D training for hip, knee and back

If you are diagnosed with osteoarthritis of the hip or knee or long-term (more than three months) or recurring back pain, we may choose to cover a GLA:D training programme based on a professional assessment. The healthcare team can refer you directly for treatment.

We will refer you to your GP in cases where we believe that for medical reasons you should be seen by a doctor before starting treatment.

The length of the course of treatment depends on a professional assessment based on the Danish Health Authority's guidelines for GLA:D programmes. Treatment can take place in our network or with a therapist of your choice.

For GLA:D training, there is no limit of six months of treatment from the date of diagnosis.

The therapist's fee is covered – up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the indexed rates in the collective agreement.

A maximum of one GLA:D programme can be covered during the insurance period per disease region (knee, hip, back). We consider the programme to be completed if you choose to discontinue treatment prematurely.

In cases where we cannot cover GLA:D training for your condition, cover for regular physiotherapy will apply.

Chiropractor

Based on a professional assessment, the healthcare team will refer you to chiropractic care either in our quality-assured network or to a therapist of your choice. The healthcare team will assess whether you need a medical assessment/recommendation in relevant cases. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments.

5.8 Mental health

The insurance covers reasonable and necessary treatment prescribed by a psychiatrist, psychotherapist or authorised psychologist (authorised cand.psych.) in Denmark.

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

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

Psychologist and psychotherapist

The insurance covers medically justified individual treatment with a psychologist or psychotherapist for the following conditions:

- Mild to moderate depression according to a psychometric test (depression score)
- Anxiety
- Adjustment reaction
- Stress reaction
- Stress.

The disorder must be symptomatic, and there must be a medical need for treatment. You must always have a valid referral or recommendation from your doctor.

The treatment must ensure progression/improvement of the condition. Mental disorders that, in our judgement, cannot be cured or permanently improved are not covered. Recurring disorders that have previously been treated via the insurance are not covered.

Preventive and maintenance treatment is not covered.

Treatment in Dansk Sundhedssikring's network

The insurance covers treatment in our quality-assured network. Following a professional assessment, we can refer you to individual face-to-face or online/digital treatment with a psychologist or psychotherapist in our network.

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

Psychiatrist
The insurance covers necessary GP-referred consultations with a psychiatrist if we assess that it is possible to achieve a significant and lasting improvement in your state of health. It is a prerequisite for cover that the disorder is eligible for cover. The consultations are allocated in portions, and we refer you to a therapist. You can also choose which psychiatrist to use. In this case, the insurance covers the therapist's fee, up to a maximum of DKK 2,000 per consultation.

The following disorders are covered:

- Mild to moderate depression according to a psychometric test (depression score)
- Anxiety
- Adjustment reaction
- Stress reaction
- Stress.

Mental well-being helpline and senior counselling
When you have health insurance with Dansk Sundhedssikring, you can call for personalised counselling, guidance and support for well-being-related problems that do not require actual treatment. The mental well-being helpline is staffed by an experienced in-house counselling team, all of whom have healthcare backgrounds and can help you prevent and deal with problems before they become serious. Counselling is provided on for example:

- Private well-being issues – e.g. working life as a senior, personal crises, senior life, retirement, children, cohabitation, divorce, lifestyle, health, illness and addiction.

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

The well-being helpline is open every weekday from 9 to 16. You call via the main number, +45 70206121, and access the helpline via the menu.

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

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

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

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

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

Emergency psychological treatment abroad is not covered.

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

5.8.2 Online emergency medical service

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

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

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

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

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

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

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

The emergency medical service cannot answer questions about the health insurance, nor can it make private referrals/recommendations for specialist practices, psychological treatment, physiotherapy, etc.

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

How to use the medical service
The emergency medical service is staffed by experienced doctors on weekdays, weekends and public holidays. It is quick and easy to use the medical service using a computer, tablet or smartphone. You can book an appointment at your convenience or wait for a doctor to become available. You can also write to the doctor 24 hours a day. During opening hours, you will receive a response within one hour. The emergency medical service can be used in Denmark and when travelling abroad.

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

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

6. What the insurance does not cover

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

- Emergency treatment and acute situations that require urgent assistance and cannot wait for planned treatment (e.g. fall injuries, road traffic accidents, accidents, bone fractures, blood clots, cerebral haemorrhage, heart disease and other diagnostic areas that we and/or the public system defines as acute and which require immediate treatment (e.g. life-threatening cancer and ischaemic heart disease), as well as cancer treatment packages).
- Preventive and maintenance examinations and treatment, health examinations, health checks and other preventive check-ups.
- Chronic/permanent diseases that occurred/became symptomatic and/or were diagnosed before the insurance came into force. Chronic conditions that occur during the insurance period are covered for up to six months from the date of diagnosis if we assess that treatment will lead to a significant and lasting improvement of the condition. Examples of chronic conditions include diabetes types 1 and 2, metabolic disorders, blood disorders, hypertension, hereditary cholesterol elevation, arteriosclerosis, all types of arthritis and degenerative disorders (osteoarthritis), age-related spinal wear and tear (spondylosis), bone diseases, muscle and connective tissue diseases, bunions, sunken arches, chronic pain, fibromyalgia, Scheuermann's disease, osteoporosis, chronic bronchitis, cystic fibrosis, migraine, epilepsy, Parkinson's disease, whiplash, multiple sclerosis, ALS, ulcers, reflux, chronic intestinal inflammation, irritable bowel syndrome, glaucoma, tinnitus, Meniere's disease, cholesteatoma, endometriosis, menopausal discomforts, vaginal atrophy, hormonal disorders and the like.
- Congenital disorders and disorders that can be related to the birth/foetal stage and their consequences. Examples include tight tongue ligaments, hip dysplasia, deformities, hip dislocation and scoliosis. Assessment and treatment of asthma, leg length difference (anisomelia) and dyspraxia.
- Assessment and treatment of anal fissure, anal fistula and pilonidal cysts.
- Cosmetic treatments and surgeries and their consequences, including conditions that are considered cosmetic for the purpose of these conditions, such as breast augmentation and reduction surgeries, breast reconstruction, cosmetic implant problems, brow lifts, drooping eyelids (lower and upper) and gynaecomastia. Botox or Xiapex treatments or treatments of sweating.
- Treatment or surgery for overweight/obesity and its consequences, including gastric bypass and excess skin surgery after weight loss. Psychological treatment for obesity.
- Treatment of warts, benign moles and spots, lipomas, acne, eczema, psoriasis, vitiligo, rosacea, sun damage to the skin, skin transplants, actinic and seborrhoeic keratosis and similar skin conditions.
- Discomforts, infections and other consequences of implants, tattoos, piercings, prostheses and the like. Complications after treatment/surgery performed in the public or private healthcare system. Replacement of prostheses and implants that can be carried out in the public sector.

- Venereal diseases, HIV/AIDS and its precursors and sequelae. All forms of contraception, including sterilisation, insertion and removal of IUDs (also applies to menorrhagia) and their consequences. Assessment and treatment of sexual dysfunction. Assessment and treatment of gender dysphoria.
- Treatment and assessment of ADHD with subtypes, Asperger's syndrome and autism spectrum disorders, dementia, Tourette's syndrome, eating disorders and their consequences.
- Treatment of severe mental illness, e.g. bipolar disorder, personality disorders, schizophrenia, psychoses, PTSD and diagnosed complicated grief. Treatment of diagnosed mental illnesses that fall under the public treatment packages.
- Behavioural treatment by a psychologist, e.g. temperamental problems, infidelity, kleptomania, comfort eating and addiction.
- Couples therapy, parental and family counselling, family therapy, coaching, self-development, personal development and similar, supportive and maintenance counselling and psychological treatments of a preventive nature.
- Treatment of phobias, such as fear of flying, fear of heights, exam anxiety and social phobia. Treatment of OCD, OCD anxiety and its sequelae. Recurrent cases of panic disorder, anxiety attacks and generalised anxiety disorder.
- Medical records, certificates, psychological and cognitive tests, specialist medical certificates, doctor's referrals, doctor's recommendations not ordered by us, participation in meetings with municipalities, schools and others.
- Consultations with a neuropsychologist.
- Talk therapy and medication by a psychiatrist.
- Cardiac arrhythmias, including radiofrequency ablation (RFA) and DC conversion and cardiac surgery.
- Assessment and treatment of sleep problems and sleep disorders, e.g. sleep apnoea and snoring treatment. Treatment at a sleep clinic.
- All types of dental treatment, dental surgery, jaw surgery and occlusal splints.
- Treatment of abuse of medication, alcohol, narcotics or other intoxicants and related disorders.
- Visual and hearing impairment, including strabismus, joint vision problems, vision correction, vitrectomy, glasses, contact lenses and/or vision tests, surgery for shortsightedness, farsightedness and astigmatism, vision-correcting lens in connection with cataract surgery, hearing improvement treatment, hearing aids and hearing tests.
- Treatments outside normal working hours, including weekend and evening supplements and similar supplements, as well as extra services such as shockwave, laser treatment, ultrasound, acupuncture, massage and the like. Additional expenses for soles, inserts, bandages, tape, etc.
- Injuries arising from or during the performance of professional sports. Professional sport is defined as the practice of sport where you receive payment from a sports club or sponsors and where the sport is practised as your main occupation.

- Illness/injury caused directly or indirectly by self-inflicted intoxication, the influence of narcotics, medication or other intoxicants. Self-inflicted injury caused by intent or gross negligence, e.g. fights, suicide attempts or participation in criminal offences. Injuries caused by your failure to follow medical recommendations.
- Injury/illness resulting from war or warlike acts and conditions, including civil war, civil unrest, rebellion, revolution, terrorism, bacteriological and chemical attacks, nuclear reactions, atomic energy, radioactive forces, radiation from radioactive fuel and waste, epidemics, pandemics, viral infections and related vaccines.
- Examination/treatment that is not medically justified or has proven efficacy. Experimental and alternative treatments/therapists, e.g. naturopaths, hypnotists and body therapists.
- Growth factor and orthokine therapy, PRF therapy, PRP therapy, hyaluronic acid (injections) and Modic changes.
- Consultations with general practitioners, specialists in general medicine or foreign doctors who are comparable to them.
- Examination and treatment that we consider complicated and highly specialised, and which we believe is best performed in the public healthcare system. Examples include complex re-constructions, organ donation and transplantation, dialysis treatment, sex change operations, proton therapy and stem cell treatment.

7. General provisions

Communication
We send letters and documents digitally. We use digital platforms such as e-Boks, the insurance company's user portal and mit.dk when we communicate with you about your insurance. We send invoices, notifications, premium increases and similar information about your insurance via digital platforms. When you receive digital letters and documents, they have the same legal effects as when you receive regular mail. This means that you must open and check what we send to you digitally. If you are exempt from digital mail, e.g. for having e-Boks, you must notify us. We will then send your letters and documents by email or regular mail. Communication with you in connection with your reported claims takes place either by phone or via the claims function on the insurance company's user portal.

7.1 Duration of the insurance

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

7.2 Sum insured

The sum insured is DKK 250,000 per person per insurance year. The amount is fixed and is not adjusted. If an insured person uses up the sum insured, no further expenses are covered.

7.3 Payment of the insurance

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

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

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

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

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

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

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

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

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

7.4 Premium adjustment and changes to insurance conditions

The premium is adjusted once a year, unless otherwise agreed. The premium is set once a year on the annual renewal date. The premium adjustment is based on the last year's claims accounts and changes in the net price index.

The premium adjustment is not limited to changes in the net price index and/or statutory changes. If this happens, you can choose to terminate the contract in writing, no later than the current month plus one month after you received the notification of the renewal premium.

If the premium is based on assumptions that no longer exist, we may adjust the premium at the next annual renewal date. If risk accounts are 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 premium for already established schemes with one month's notice to the end of a month. The premium will be adjusted by a percentage set by Dansk Sundhedssikring.

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

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

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

7.5 Termination and cessation of the insurance

The insurance policy, which is taken out for one year at a time, is automatically renewed from the annual renewal date.

The policyholder can terminate the insurance in writing giving a notice of current month plus one month. Termination at the renewal date is free of charge. Termination at other times is subject to an administration fee.

Dansk Sundhedssikring can terminate the insurance in writing giving a notice of current month plus one month. In the event of signs of fraud or attempted fraud, we can cancel the insurance without notice.

The insurance ends at the end of a month if you no longer have a registered address in Denmark.

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

Cover on termination of the insurance

When the insurance is terminated, you lose the right to cover after six months for claims that have already been reported and approved. A new claim must always be reported no later than six months after the termination of the insurance. The claim must always have occurred during the insurance period. If you have a referral from your GP, this must always be dated during the insurance period. Disease/disorder occurring after the expiry of the insurance or referrals dated after the expiry of the insurance are not covered by the insurance and are not covered.

Cover requires that we have received all necessary information, e.g. a doctor's referral.

Reimbursement of bills after termination of the insurance

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

7.6 Duty of disclosure

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

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

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

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

Double insurance

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

7.7 Processing of personal data

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

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

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

7.8 Processing of health information

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

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

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

Disclosure of health information is only made in connection with the examination/treatment of the reported disorder/injury in accordance with section 41 of the Health Act on disclosure of health information, etc. in connection with the treatment of patients.

7.9 Incorrect information

The insurance requires correct information. If you provide incorrect information – or withhold information – when the insurance is taken out or at a later date, the cover may be cancelled in whole or in part.

7.10 Time limitation

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

7.11 Avenues of complaint

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

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

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

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

Governing law

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

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

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

7.12 If you want to know more

If you want to know more about your insurance, you can contact Dansk Sundhedssikring by phone on +45 70206121 or by email at sundhedsforsikring@ds-sundhed.dk. You can also find more information on our website, ds-sundhed.dk, where you can also report your claim online.

7.13 Right of cancellation

A right of cancellation applies to insurance taken out by private individuals. This means that the policyholder can cancel a privately concluded insurance contract in accordance with the rules in section 34 of the Insurance Contracts Act. According to the rules in the Insurance Contracts Act, the policyholder is entitled to receive certain information, including information about the right of cancellation and the service ordered.

If you regret having privately taken out an insurance policy, you have a 14-day right of cancellation. The right of cancellation starts from the date on which the contract is concluded and you have been informed of the insurance conditions, which also describe the right of cancellation. If the cancellation period expires on a public holiday, Saturday, Constitution Day (5 June), Christmas Eve (24 December) or New Year's Eve (31 December), the period does not expire until the following working day.

Before the end of the cancellation period, you must notify us in writing that you have cancelled the contract. You can notify us by letter or e-mail. The letter or e-mail must be sent before the end of the cancellation period.

You must send your cancellation notice to:

Dansk Sundhedssikring
Hørkær 12B
2730 Herlev

E-mail: sundhedsforsikring@ds-sundhed.dk