DANSK SUNDHEDS SIKRING

Terms – Private Critical Advantage

Version 1.1 | Forsikringsselskabet Dansk Sundhedssikring A/S | Q2 | 2023

DANSK SUNDHEDS SIKRING

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Forsikringsselskabet Dansk Sundhedssikring A/S
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1. Basis for the agreement

These insurance conditions are valid from 1 July 2023.

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 and the Financial Business Act.

The insurance contract applies between Dansk Sundhedssikring A/S and the person named as the Policyholder.

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

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

Further
Further Underwriting International SLU ("Further"), a company that arranges the following services associated with the Policy: ***Second Medical Opinion Service*** and ***Medical Concierge Service.***

Commencement Date
The date coverage starts as indicated in the insurance contract.

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

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

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

Indemnity Period
Period of thirty-six (36) months that commences from the date of the first trip that is arranged and paid for by the Policy in a valid claim. A separate Indemnity Period is established per Coverage Module (the Applicable Indemnity Period) when the first claim for that Coverage Module is accepted and results in a trip being arranged and paid for by the policy. The Applicable Indemnity Period is the length of time for which the benefits of the Policy are payable for all claims accepted under the same Coverage Module.

Sum Insured
The maximum amount payable as defined in the insurance contract in the event of a Covered Diseases or Medical Procedures.

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.

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1.2 Medical definitions

Gene Therapy Products: These contain genes that lead to a therapeutic, prophylactic or diagnostic effect. They work by inserting 'recombinant' genes into the body, usually to treat a variety of diseases, including genetic disorders, cancer or long-term diseases. A recombinant gene is a stretch of DNA or RNA that is created in the laboratory, bringing together DNA or RNA from different sources.

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

Tissue-Engineered Products: These contain cells or tissues that have been modified so they can be used to repair, regenerate or replace human tissue.

Alternative Medicine: Medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine or the standard treatments, including but not limited to: acupuncture, aromatherapy, chiropractic medicine, homeopathic medicine, naturopathic medicine, Ayurveda, traditional Chinese medicine and osteopathic medicine.

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

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

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

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

Disease: Any or disorder of the body, system, or organ structure or function with identifiable and characteristic set of signs and symptoms, or consistent anatomic alterations. Additionally, a diagnosis has to be made by a doctor legally registered in his practice. A Disease will be considered to be all the Injuries and effects arising from the same diagnosis, as well as all the ailments due to the same cause or related causes. If an ailment is due to the same cause that produced a previous Disease or a related cause, the Disease shall be considered as a continuation of the previous one and not as a separate Disease.

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Medically Necessary: Healthcare services or supplies which are prescribed to the Insured Party for the purpose of treating a Covered Disease or arranging a Covered Medical Procedure with the aim to improve the Insured Party's medical condition and recognised as effective in improving health outcomes following treatment plans that are consistent in type, frequency and duration with the diagnosis according to published peer-reviewed medical literature. The healthcare services or supplies must be cost-effective compared to alternative treatments that result in similar outcomes, including no treatment and those required for reasons other than the convenience of the Insured Party or his/her doctor. The fact that a doctor may recommend, prescribe, order or approve, a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Policy.

Preliminary Medical Certificate: Written approval, issued by FURTHER and/or the Insurance Company, which includes confirmation of cover under the Policy prior to the treatment abroad being performed in the indicated hospital, for any treatment, services, supplies or prescriptions relating to a claim.

Pre-Existing Diseases: Any Diseases or medical condition of the Insured Party which were reported, diagnosed, treated or which showed related medically documented symptoms or findings (signs) within the 5 years prior to the Commencement Date (or the relevant inclusion date of the Insured Party).

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

Reconstructive Surgery: Procedures intended to rebuild a structure to correct its loss of function.

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2. Who the insurance covers

The Insured Party must have:
1. a permanent National Registration Office address in Denmark (excluding Greenland and the Faroe Islands), and
2. have a Danish health insurance card and
3. be entitled to receive Denmark's public health insurance benefits.

All benefits under treatment abroad are covered outside of Denmark. After completing treatment abroad, the medication and follow-up care benefits are covered in the Denmark only, except if the medication or/and follow-up care is not available in Denmark, see section 6.5.1 and 6.5.2.

Exceptions will be stated in the contract.

2.1 Who the insurance covers

The insurance can be taken out by private individuals who have reached the age of 18.
The insurance can be taken out while the individual is aged 18-64.
You can be insured until the 85th year.

2.2 Co-insured

It is possible to co-insure a spouse/cohabitant/child for a separate price.

Eligibility rules for spouse/cohabitant

- The spouse/cohabitant can be insured when they have reached the age of 18.
- The insurance can be taken out for a spouse/cohabitant while the individual is aged 18-64.
- The spouse/cohabitant can be co-insured until their 85th birthday. The Insured Party must always notify us if changes occur in their relationships that affect who should be covered by the insurance contract.

Eligibility rules for children

- Children who can be subscribed are:
  a) your biological children and/or adoptive children and
  b) 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.
- The insurance can be taken out for a child while the individual is aged 0-26.
- Children can be co-insured until their 27th birthday. Cover ends at the annual policy anniversary following the 27th birthday. 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 Qualifying Provisions

There is no qualifying period for Pre-Existing Diseases. 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 insurances issued under "***Terms – Trade and Industry Critical Advantage***" in observation of section "***Continuation of the insurance***" included in section "***8.5 Cancellation and termination of the insurance.***"
This means Pre-Existing Diseases will be considered in relation to the Commencement Date (or the relevant inclusion date of the Insured Party) set in the original group insurance.

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3. What the insurance covers

The insurance covers the examination and treatment of diseases, with the aim to improve the Insured Party's medical condition. We assess which examination or treatment is necessary.

The object of this insurance is to provide the Insured Party with cover for the services and medical expenses in respect of treatment for Covered Diseases and Covered Medical Procedures as defined in this section 3.

Services:

Second Medical Opinion Service: A Second Medical Opinion in respect of covered conditions. This involves the provision of a second medical opinion report, following the collection and a detailed review of a patient's medical records, by an expert medical specialist.

The Insured Party will be entitled to request Further, at the point of notification of claim, a Second Medical Opinion Service for confirmation of the diagnosis of a Covered Disease or Medical Procedure and the assessment of the optimal treatment plan.

The Second Medical Opinion Service can only be requested once per claim.

Medical Concierge Service: In a respect of an approved claim, a Medical Concierge Service arranges all details relating to the medical treatment of an individual. This includes oversight of the case and assistance with travel and accommodation arrangements for the individual and any eligible companion.

Covered Diseases:

Coverage Module 1: Cancer Treatment

The insurance covers treatment for the following types of cancer:

1. Any malignant tumour including leukaemia, sarcoma and lymphoma characterised by the uncontrolled growth and spread of malignant cells and the invasion of tissues;
2. Any In-situ cancer which is limited to the epithelium where it originated and did not invade the stroma or the surrounding tissues.
3. Any pre-cancerous change in the cells that are cytologically or histologically classified as high-grade dysplasia or severe dysplasia.

However, please note that treatment for the following forms of cancer will be excluded:

- Any tumour in the presence of Acquired Immune Deficiency Syndrome (AIDS).
- Any non-melanoma skin cancer that has not been histologically classified as having caused invasion beyond the epidermis (the outer layer of the skin).
- Any treatment involving CAR T-cell therapy.

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Covered medical procedures:
The following covered medical procedures are covered by the insurance when the underlying Disease which is the subject of the procedure is not related to cancer treatment.

Coverage Module 2: Cardiovascular Procedures

Coronary artery by-pass surgery (myocardial re-vascularisation)

The undergoing of surgery on the advice of a consultant cardiologist to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

Please note that the following treatments will be excluded:

- Any coronary disease treated using techniques other than the by-pass of the coronary arteries, like any kind of angioplasty surgery, stents.

Heart valve replacement or repair

The invasive replacement or repair of one or more heart valves, independent of whether this is performed with open chest surgery, minimally invasive or by means of cardiac catheter treatment on the advice of a consultant cardiologist.

Coverage Module 3: Neurosurgery

Intracranial and specific spinal cord surgery
- Any surgical intervention of the brain or any other intracranial structures.
- Treatment of benign tumours located in the spinal cord (Medulla spinalis).

Coverage Module 4: Transplants

Live-Donor Organ Transplant
Surgical transplant in which the Insured Party receives a kidney, a segment of liver, a pulmonary lobe or a section of pancreas from another living compatible donor.

Please note that the following treatments will be excluded:

- Any transplant when the need for a transplant arises as a consequence of alcoholic liver disease.
- Any transplant when the transplant is conducted as a self-transplant.
- Any transplant when the Insured Party is a donor for a third-party (not covered by the Policy).
- Any transplants from a dead donor.
- Any organ transplant that involves stem cell treatment.
- The transplant is made possible by the purchase of donor organs.

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Bone Marrow Transplant

Bone Marrow Transplantation (BMT) or Peripheral Blood Stem Cell Transplantation (PBSCT) of bone marrow cells to the Insured Party originating from:

- the Insured Party (autologous bone marrow transplant); or
- from a living compatible donor (allogeneic bone marrow transplant).

Please note that Haemopoietic Stem Cell Transplantation (HCT) using the umbilical cord blood will be excluded.

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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.

The insurance contract provides cover to the Insured Party when when all the following conditions are met:

4.1 Indemnity Period

The medical services and procedures offered as benefits of the insurance contract are performed during the applicable Indemnity Period. The applicable Indemnity Period lasts 36 months and commences on the date of the first trip to receive treatment abroad.

4.2 The Disease is not a pre-existing condition

The Disease must occur during the Insurance Period. Diseases that have occurred and/or are diagnosed for up to 5 years before the Insurance Period, are not covered. This also applies to related symptoms or findings (signs) that are medically documented during the same period of 5 years.

4.3 Medically Necessary Treatment

The treatment should, in our opinion, be Medically Necessary and expected to cure the disorder or significantly and permanently improve the state of health. Treatments of a preventive nature are not covered. We consider Medically Necessary Treatment to include all healthcare services or supplies which are:

- prescribed to the Insured Party for the purpose of treating a Covered Disease or arranging a covered medical procedure with the aim to improve the Insured's party medical condition and;
- recognised as effective in improving health outcomes following treatment plans that are consistent in type, frequency and duration with the diagnosis according to published peer-reviewed medical literature (such as Pubmed) or scientifically based US, UK and or European guidelines (specifically, NCCN Clinical Practice Guidelines in Oncology will be applied with respect to Cancer Treatment: Coverage Module 1) and;
- cost-effective compared to alternative treatments that result in similar outcomes, including no treatment and;
- required for reasons other than the convenience of the Insured Party or his/her doctor.

The fact that a doctor may recommend, prescribe, order or approve, a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Policy. The treatment method is covered by the insurance only if it is approved by us.

4.4 Expenses

The expenses and monetary benefits must be within the sum insured and limits stated in the table of benefits included in your individual cover. All expenses must be reasonable and necessary in our opinion in relation to the expected outcome.

We will refer you to a clinic or private hospital for treatment abroad, and the payment will take place directly between the treatment centre abroad and us.

4.5 Treatment is arranged by Further

The treatment is arranged by Further in accordance with the claims procedure set out in section 5.

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4.6 Medical expenses
The medical expenses arising outside the country of residence (and Denmark for those employees residing outside of Denmark) with the exception of

- the medication expenses covered in section 6.5.1.
- the follow up care expenses covered in section 6.5.2.

The expenses for any medical diagnostic procedures, treatment, services, supplies or prescriptions are covered by the insurance contract as stated in section 6.

4.7 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 issued via the Preliminary Medical Certificate, as we may otherwise reject cover. This also applies if changes occur in the treatment that you have agreed with us.

4.8 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 which is unrelated to the Covered Disease or covered medical procedures.
Please refer to section 6.2.(5) for clarification on complications or side effects.

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

4.10 Ongoing and planned treatment.
Treatments that have been initiated or planned before this insurance commences are generally not covered.
Please refer to section 7 for clarification on the coverage for Pre-Existing Diseases.

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5. Claims procedure

Prior to receiving any treatment, service, supply or medical prescription in relation to a Covered Disease or medical procedure, as defined in section 3, the Insured Party, or any person acting legally on his/her behalf, must comply with the following procedure:

5.1 Making a claim

Claims must always be made during the insurance period.

Claims can be filed by contacting Dansk Sundhedssikring by telephone at +45 70206121.

If you have questions about your insurance policy, you can contact the healthcare team on weekdays by telephone +45 70206121 or at the e-mail address: sundhedsforsikring@ds-sundhed.dk.
If your inquiry concerns an existing and ongoing claim, you can contact Further at claims@wegofurther.com.

5.2 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 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.

The Insured Party will be informed of the steps required to provide Further with all the relevant diagnostic tests and medical documents necessary to evaluate the validity of the claim.

Should the Insured Party request the second medical opinion service (see section 6.1), this service will need to be completed prior to confirmation of cover of the claim under the insurance.

5.3 Obligation of the Insured Party

The Insured Party is obliged to cooperate with Further providing free access to medical documents in the possession of the Insured Party or the doctors, hospitals or other medical facilities responsible for treatment up to the date the potential claim was notified.

Any claim request will only be evaluated for cover under the insurance when all the necessary information has been received from the Insured Party and respective doctors, hospitals or other medical facilities.

5.4 Claim assessment and proposal of hospital for treatment

Upon receipt of all the relevant diagnostic tests and medical history as requested by Further, the Insured Party will be notified if the claim is covered under the insurance.

In the event that the Insured Party wishes to consider treatment abroad, the Insured party will be provided with a list of recommended hospitals.

In the event that the Insured Party wishes to consider treatment abroad, Further will assess the availability of the applicable Indemnity Period resulting in one of the following scenarios:

- Scenario 1: Full availability
  There has been no previous claim under the relevant coverage module that resulted in treatment being arranged and paid for by the insurance. Therefore, Further will confirm the full availability of 36-months for the applicable Indemnity Period.

- Scenario 2: Partial availability
  There has been previous claim(s) under the relevant coverage module that resulted in treatment being arranged and paid for by the insurance. Therefore, Further will confirm the availability of the remaining months for the applicable Indemnity Period.

- Scenario 3: The applicable Indemnity Period expired
  There has been previous claim(s) under the relevant coverage module that resulted in treatment being arranged and paid for by the insurance, reaching the expiry of the applicable Indemnity Period. Therefore, Further will confirm the claim is not eligible under the insurance.

Under the scenarios 1 and 2, the Insured Party will be provided with a list of recommended hospitals.

5.5 Treatment abroad: the Preliminary Medical Certificate

Upon receipt of the Insured Party's confirmation of his/her decision to receive treatment abroad at a hospital selected from the list of recommended hospitals for treatment, and provided the treatment is scheduled to commence before the expiry of the applicable Indemnity Period, Further will arrange through the Medical Concierge Service the necessary logistical and medical arrangements for the correct admission of the Insured Party and a Preliminary Medical Certificate will be issued valid only for that hospital.

The Medical Concierge Service is a service whereby Further, in respect of an approved claim arranges all details relating to the medical treatment of an individual. This includes oversight of the case and assistance with travel and accommodation arrangements for the individual and any eligible companion.

The list of recommended hospitals and the Preliminary Medical Certificate are issued on the basis of the medical condition of the Insured Party at the time of issue. Since the health condition of the Insured Party may change over time, both documents will have a validity of three months.

In the event that the Insured Party does not select a hospital from the list of recommended hospitals or does not initiate treatment at the approved hospital stated in the Preliminary Medical Certificate within three months of issue, new versions of these documents may be reissued based on the health condition of the Insured Party at that time.

As long as the terms of the Preliminary Medical Certificate are met, the Company, under the benefits of the insurance, will directly assume the medical expenses covered and the necessary travel and accommodation arrangements subject to the limitations, exclusions and conditions detailed in the insurance.

5.6 The applicable Indemnity Period

The applicable Indemnity Period lasts 36 months and commences on the date of the first trip to receive treatment abroad.

The policy will cover the services, expenses and monetary benefits (up to the limits shown in the table of benefits) arising in connection with this valid claim under the insurance for the duration of the applicable Indemnity Period.

In the event that the Insured Party is hospitalised or under the care of a hospital under the terms of the Preliminary Medical Certificate as of the end of the applicable Indemnity Period, the insurance will continue to provide cover for

the medical expenses stated in section 6.1 until the next scheduled return to the country of residence based on the established treatment plan.

5.7 Return from treatment abroad

In the event that the final return to the country of residence occurs before the end of the applicable Indemnity Period, Further will present the Insured Party with the guidelines to benefit from the covered medical expenses after returning from treatment abroad detailed in section 6.5. These guidelines will be based on the recommendations from the international doctor(s).

Under this scenario the Insured Party will be entitled to:

- benefit from the medication expenses detailed in section 6.5.1 and
- benefit from the follow-up care benefit as detailed in section 6.5.2 until the end of the applicable Indemnity Period.

5.8 Assessment of claims after return from treatment abroad

Upon the final return of the Insured party to the country of residence, after completing the treatment plan, the evolution of the Insured Party's state of health may determine that a new assessment for further Medically Necessary Treatment may be required. Provided the insurance is still active and within the applicable Indemnity Period, the Insured Party will be entitled to contact Further to complete this assessment.

Further will then reinform the Insured Party of the steps required to provide Further with all the relevant diagnostic tests and medical documents necessary to complete this assessment.

In the event that the assessment by Further confirms that further Medically Necessary Treatment is required, this will be confirmed to the Insured Party by issuing a new preliminary medical certificate, with the resulting list of recommended hospitals and potential treatment abroad (as detailed section 5.4 and 5.5.).

The assessment may require, when medically justified in the view of Further, the completion of a new Second Medical Opinion Service.

The insurance will continue to provide cover for all services and medical expenses (as detailed in section 6.2) until the end of the applicable Indemnity Period under the terms of the latest Preliminary Medical Certificate.

5.9 Collaboration

The Insured Party and his/her relatives must allow visits by doctors working for Further and/or the Company and any enquiries considered necessary by the Company, for which purpose the doctors who have visited and attended the Insured Party shall be released from the obligation to maintain professional secrecy.

Failure to allow these visits will be considered by the Company as an express waiver of the right to provide the benefits on the relevant claim covered by the Policy.

6. Coverage

The insurance will cover the following services, expenses and monetary benefits (up to the limits shown in the table of benefits) arising in connection with a valid claim under the insurance.

The services must be arranged, and the expenses must be incurred within the applicable Indemnity Period.

This section contains the different elements of cover under the insurance:

6.1 Services covered prior to receiving treatment abroad

The Insured Party will be entitled to request to Further at the point of notification of claim, a Second Medical Opinion Service for confirmation of the diagnosis of a Covered Disease or recommendation for a covered medical procedure and the assessment of the optimal treatment plan.

This service involves the provision of a Second Medical Opinion report, following the collection and a detailed review of a patient's medical records, by an expert medical specialist.

The Second Medical Opinion Service can only be requested once per claim.
Should the Insured Party request the Second Medical Opinion Service, this service will need to be completed prior to confirmation of cover of the claim under the insurance.

6.2 Medical expenses covered during treatment abroad

The Preliminary Medical Certificate is a written approval, issued by Further, which includes confirmation of cover under the Insurance contract prior to the treatment abroad being performed at the indicated hospital, for any treatment, services, supplies or prescriptions relating to a claim.

The Insurance contract will pay the following medical expenses for treatment abroad (up to the limits shown in the table of benefits) arising in connection with the Medically Necessary Treatment of Covered Diseases and medical procedures as per the terms set in the preliminary medical certificate:

1. By a hospital, in respect of:
    - Accommodation, meals and general nursing services provided during the Insured Party's stay in a room, ward or section of the hospital or in an intensive care or monitoring unit;
    - Other hospital services including those provided by a hospital outpatient department (including a medical interpreter), as well as expenses relating to the cost of an extra or companion's bed if the hospital provides this service;
    - The use of an operating room and all the services included in it.

2. By a day clinic or independent welfare centre, but only if the treatment, surgery or prescription would have been covered under this insurance contract if provided in a hospital.

3. By a doctor, in respect of examination, treatment, medical care or surgery.

4. For doctors' visits during hospitalisation.

5. For the following medical services, treatments or prescriptions:
    - For anaesthesia and administration of anaesthetics, provided they are performed by a qualified anaesthetist;
    - Laboratory analysis, pathology and x-rays for treatment preparation purposes, radiotherapy, radioactive

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isotopes, chemotherapy, electrocardiograms, echocardiography, myelograms, electroencephalograms, angiograms, computerised tomography and other similar tests and treatments required for the treatment of a Covered Disease or medical procedure, when performed by a doctor or under medical supervision;
- Blood transfusions, administration of plasma and serum;
- Expenses relating to the use of oxygen, application of intravenous solutions and injections.
- Radiation therapy: high-energy radiation to shrink tumours and kill cancer cells by X-rays, gamma rays, and charged particles are types of radiation used for cancer treatment either delivered by a device outside the body (external-beam radiation therapy), or by radioactive material placed in the body near cancer cells (internal radiation therapy, brachytherapy).
- Reconstructive surgery to repair or rebuild a structure damaged or removed by the medical procedures arranged and paid for by this insurance contract.
- Treatment for complications or side-effects directly associated with the medical procedures arranged and paid for by this insurance contract that:
    1. demand immediate medical attention in a hospital or clinical setting and
    2. require to be addressed prior to the Insured Party being declared medically fit to travel to return to the country of residence after the completion of the stage of treatment abroad.

6. For medication applied by medical prescription while the Insured Party is hospitalised for treatment of a Covered Disease or medical procedure. Medication prescribed for post-operative treatment are covered for 30 days from the date the Insured Party has completed the treatment abroad stage of treatment and only when these are purchased prior to returning to the country of residence.

7. For transfers and transportation by ground or air ambulances where their use is indicated and prescribed by a doctor and pre-approved by Further.

8. For services provided to a living donor during the process of removal of an organ to be transplanted to the Insured Party, arising from:

- The cost of the analysis and test performed to identify the suitable donor within the family members of the Insured Party;
- Hospital services provided to the donor, including accommodation in a hospital room, ward or section, meals, general nursing services, regular services provided by hospital staff, laboratory tests and use of equipment and other hospital facilities (excluding items for personal use which are not required during the process of removal of the organ or tissue to be transplanted);
- For surgery and medical services for the removal of a donor's organ or tissue to be transplanted to the Insured Party.

9. For services and materials supplied for bone marrow cultures in connection with a tissue transplant to be applied to the Insured Party, cover will only be provided for expenses incurred from the date of issue of the Preliminary Medical Certificate.

6.2.1 Force majeure

In the event that any force majeure or logistical or operational restrictions imposed by local or international authorities impede Further from making arrangements for treatment abroad, then Further will arrange the provision of the benefits set out in this section 6.2 (Medical expenses covered during treatment abroad) in the country of residence provided that the same logistical or operational restrictions do not impede the arrangement of an equivalent and medically viable alternative in the country of residence.

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Benefits set out in this section 6.2 will be available in the country of residence only until such time as Further is able to confirm the reestablishment of arrangement of treatment abroad. The benefits, arranged and established by Further, and provided in the country of residence will be paid in excess of any funding provided by the public health service of the country of residence or an insurance established with Dansk Sundhedssikring.

6.3 Non-medical expenses covered during treatment abroad

The insurance contract will cover the following non-medical expenses (up to the limits shown in the table of benefits) arising in connection with the travel, accommodation arrangements made by Further in order to provide the Insured Party with access to the medical treatment as per the terms set in the Preliminary Medical Certificate.

Travel and accommodation arrangements are covered for the Insured party, travelling companion (or two companions, when the Insured Party receiving treatment is a minor) with each trip including the travel from the country of residence to the treatment destination and return plus the necessary accommodation arrangements for the complete duration of each trip.

The dates and duration of the trips will be established by Further on the basis of the treatment plan schedule indicated by the treating international doctor(s).

Travel and accommodation arrangements for each covered trip are covered as per the terms set below:

Travel expenses for treatment abroad

For travel outside the country of residence of the Insured Party, travelling companion (or two companions, when the Insured Party receiving treatment is a minor) and where applicable the living donor in the case of transplant with the sole purpose of receiving treatment abroad as approved by Further / the Company in the Preliminary Medical Certificate. All travel arrangements must be made by Further and the Company will not pay for any travel arrangements made by the Insured Party or any third party on the Insured Party's behalf.

Further will be responsible for deciding the travel dates for each covered trip based on the approved treatment schedule. These dates will be communicated to the Insured Party to allow for sufficient time for the Insured Party to make all the necessary personal arrangements.

In the event that the Insured Party changes the travel dates from those communicated by Further / the Company, the Insured Party will need to compensate the Company and/or Further for all the associated costs of organising and providing new travel arrangements, unless the changes have been confirmed by Further as necessary from a medical standpoint.

The travel expenses covered will include:

- Transportation from the Insured Party's permanent address to the designated airport or international rail station.
- Economy class rail or air ticket to the city of treatment destination and the transportation to the designated hotel.
- Transportation from the designated hotel or hospital to the designated airport or international rail station.
- Economy class rail or air ticket and subsequent transportation to the city of the Insured Party's permanent address.

The travel expenses covered will not include regular transfers from the hotel to the hospital or treating doctor during the duration of the treatment abroad.

Accommodation expenses covered during treatment abroad

For the accommodation, outside the country of residence, of the Insured Party, travelling companion (or two companions, when the Insured Party receiving treatment is a minor) and the living donor in the case of transplant, with the sole purpose of receiving treatment abroad as approved by Further / the Company in the Preliminary Medical Certificate. All

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accommodation arrangements for each covered trip must be made by Further and Further / the Company will not pay for any accommodation arrangements made by the Insured Party or any third party on the Insured Party's behalf.

Further will be responsible for deciding the accommodation booking dates for each covered trip based on the approved treatment schedule. These dates will be communicated to the Insured Party to allow for sufficient time for the Insured Party to make all the necessary personal arrangements.

Further will provide a return date for each covered trip based on the agreement with the treating doctor that the Insured Party is fit to travel.

In the event that the Insured Party changes the dates of travel from those booked and communicated by Further, the Insured Party will need to compensate the Company and/or Further for all the associated costs of organising and providing new accommodation arrangements, unless the changes have been confirmed by Further as necessary from a medical standpoint.

The accommodation arrangements will include:
- Bookings for a double room or twin bedroom in a three or four-star hotel, including breakfast.
- (The choice of hotel will be subject to availability and based on the proximity to the hospital or treating doctor within a radius of 10 km.)

Meals (excluding breakfast) and incidental costs at the hotel are not covered. Upgrades at the hotel cannot be financed by the Insured Party.

Repatriation expenses
In the event the Insured Party (and/or living donor in the case of transplant) dies outside the country of residence while receiving treatment abroad, the Company will pay for the repatriation of the deceased's remains to the country of residence.

This coverage is limited to only those services and supplies necessary to prepare the deceased's body and transport to the country of residence, including:

- The services provided by the funeral company providing the international repatriation, including embalmment and all administrative formalities.
- The minimum obligatory coffin.
- The transport of the deceased's remains from the airport to the designated place of burial in the country of residence.

6.4 Monetary benefits covered during treatment abroad
During treatment abroad of a Covered Disease or medical procedure and for each overnight stay in a hospital or clinic, the insurance contract will pay the Insured Party the daily hospitalisation indemnity, up to the limits shown in the individual cover document.

The confinement must be approved by Further / the Company in the Preliminary Medical Certificate.

6.5 Medical expenses covered after returning from treatment abroad

6.5.1 Medication expenses covered after returning from treatment abroad
After returning to the country of residence from treatment abroad, the insurance contract will pay for medication expenses prescribed and purchased in the country of residence, subject to the following conditions and limitations:

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1. The medication has been licensed and approved by the corresponding medical authority or agency in the country of residence, and its prescription and administration is regulated, and
2. The medication is available for purchase in the country of residence in a time and manner necessary for the continuation of the treatment, and
3. The medication requires prescription by a doctor in the country of residence, and
4. The medication is recommended by Further following the recommendations of the international doctor(s) that treated the Insured Party, as necessary for on-going treatment, and
5. The medication is following a hospitalisation outside of the country of residence of at least three overnight stays approved by Further / the Company in the Preliminary Medical Certification, and
6. Each prescription does not exceed a dose for consumption longer than 2 months, and
7. All prescriptions are issued prior to the end of the applicable Indemnity Period.

The purchase of the medication for this section 6.5.1 when performed in the country of residence needs to be arranged and paid directly by the Insured Party. The Company will reimburse the Insured Party upon receipt of the relevant prescription, original invoice and proof of payment, provided those invoices are submitted to the Company not more than 180 days after the date the expense was incurred.

Where the cost of medication has been funded in parts or in full by the public health service of the country of residence or an insurance established with Dansk Sundhedssikring, the Company will only reimburse the costs that are not funded and thus have to be paid directly by the Insured Party. The reimbursement request should clearly differentiate those costs that are directly paid by the Insured Party from the funded parts.

In the event that the recommended medication (or alternative equivalent medication with a similar effectiveness), as confirmed by Further:

- is not licensed or approved in the country of residence as mentioned in above condition of section 6.5.1 (1), or
- is not available for purchase or accessible to the Insured in the country of residence, as mentioned in above condition of section 6.5.1 (2) and
- all other above conditions of section 6.5.1 (3) through 6.5.1 (7) are still met, the Insurance contract will also pay for medication expenses outside of the country of residence.

In this event, Further will arrange the necessary travel and accommodation arrangements on the terms described in section 6.3 for the Insured Party and designated companion(s).

6.5.2 Follow up care returning from treatment abroad

In the context of this insurance follow-up care refers exclusively to any diagnostic investigation and/or monitoring/ surveillance service (by a doctor with special expertise referring to the treated Disease) post treatment abroad, used to identify whether the Insured Party is suffering (or likely to suffer) from a deterioration or complication of the treated Disease, with the purpose of preventing relapses or recurrences of the same disease.

After returning to the country of residence having completed the stage of treatment abroad, the insurance contract will cover expenses arising from follow-up care incurred in the country of residence, subject to the following conditions and limitations:

1. The follow-up care has been performed in one of the selected hospitals by Further, and
2. The follow-up care is available in the country of residence in a time and manner necessary for the on-going screening, and
3. The follow-up care is performed following the recommendations of the international doctor(s) that treated the Insured party, as necessary for on-going screening and monitoring, and
4. The follow-up care related invoices are issued prior to the end of the applicable Indemnity Period.

Follow-up care under section 6.5.2 when performed in the country of residence needs to be arranged and paid directly by the Insured Party in the country of residence. The Company will reimburse the Insured Party upon receipt of the original invoice and proof of payment, provided those invoices are submitted to the Company not more than 180 days after the date the expense was incurred.

In the event that the doctors responsible for arranging follow-up care in the country of residence indicate, following the evolution of the Insured Party's state of health, the need to work on the basis of different follow-up care guidelines from those initially established by the international doctor, Further will communicate these to the international doctor for approval and confirm, when applicable, the reimbursement of such expenses following the new accepted guidelines.

Where the cost of follow-up care has been funded in parts or in full by the public health service of the country of residence or an insurance established with Dansk Sundhedssikring, the Company will only reimburse the costs that are not funded and thus have to be paid directly by the Insured Party. The reimbursement request should clearly differentiate those costs that are directly paid by the Insured Party from the funded part.

At the request of the Insured Party and provided above conditions in section 6.5.2 (3) and section 6.5.2 (4) are still met, Further can also authorise and arrange follow up care outside of the country of residence. In this event:

- Follow-up care will be performed by the international doctor(s) that treated the Insured Party, or their medical team.
- The insurance company will directly assume the medical expenses of these consultations and diagnostic tests.
- Further will arrange the necessary travel and accommodation arrangements on the terms described in section 6.3 for the Insured Party and designated companion(s).

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7. What the insurance does not cover

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

- Expenses derived from all diseases or medical procedures not specifically contemplated under section 3.
- Any expenses for Diseases or Injuries produced as a result of wars, acts of terrorism, seismic movements, commotions, riots, floods, volcanic eruptions, as well as the direct or indirect consequences of nuclear reaction and any other extraordinary or catastrophic phenomena; as well as officially declared epidemics.
- Alcoholism, drug addiction and/or intoxicants caused by the abuse of alcohol and/or the use of psychoactive, narcotic or hallucinogenic drugs.
- The consequences and Diseases arising from attempted suicide and self-harm.
- Expenses derived from all Diseases or conditions caused intentionally or fraudulently or derived from acts of negligence or criminal imprudence by the Insured Party or resulting when committing a crime.
- A claim where the Insured Party, prior to, during or after the claim assessment process established by Further:
  - has not followed the advice, prescriptions or established treatment plan of the treating doctor or
  - refuses to receive any medical treatment or be subject to additional diagnostic analysis or tests necessary to establish a definitive diagnosis or treatment plan.
- Treatment for pre-existing Diseases. In the context of this insurance pre-existing Diseases are any Diseases or medical conditions of the Insured Party which were reported, diagnosed, treated or which showed related medically documented symptoms or findings (signs) within the 5 years prior to the commencement of the applicable insurance for each Insured Party.
- Medical treatment involving Gene Therapy, Somatic-Cell Therapy, Tissue-Engineered Therapy and CAR T-Cell Therapy.
- Experimental treatment as well as those diagnostic, therapeutic and/or surgical procedures whose security and reliability have not been widely recognised by the international science community as safe, effective and appropriate for the treatment of Disease in question or is at any stage of clinical experimentation.
- Medical procedures needed as a result of AIDS (acquired immune deficiency syndrome), HIV (human immunodeficiency virus) or any condition arising from them (including Kaposi's sarcoma), or any treatment for AIDS or HIV.
- Any health care service or supply that is not Medically Necessary for the treatment of a Covered Disease or medical procedure.
- Any alternative treatment, service, supply or medical prescription for a Disease or medical condition for which the best treatment is a transplant covered by the insurance contract (Coverage Module 4).
- Any disease or medical condition which has been caused by the medical procedures arranged and paid for by this insurance contract save where the Disease or medical condition in question is a Covered Disease or requires a covered medical procedure contemplated under section 3.

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- Treatment for long-term side effects, relief of chronic symptoms, or rehabilitation (including but not limited to physiotherapy, mobility rehabilitation, and language and speech therapy).

- In relation to the medication expenses (section 6.5.1), the following exclusions apply:
  - Any cost which is funded by the Public Health Service of the country of residence or that is covered by any other insurance established with Dansk Sundhedssikring.
  - The cost of the administration of the medication.
  - Any purchase of medication incurred outside of the country of residence unless explicitly authorised by Further / Company.
  - Invoices submitted for reimbursement to the Company more than 180 days after the date the expense is incurred.

- In relation to the follow-up care covered expenses as detailed in section 6.5.2 the following exclusions apply:
  - Any cost which is funded by the Public Health Service of the country of residence or that is covered by any other insurance established with Dansk Sundhedssikring.
  - Any expense incurred not following the guidelines established by Further.
  - Any expense incurred in a different hospital or medical facility from the authorised by Further.
  - Invoices submitted for reimbursement to the Company more than 180 days after the date the expense is incurred.

- Any expenses incurred in connection with or derived from any diagnostic procedures, treatment, service, supply or medical prescription of any nature incurred in the country of residence, with the exception of
  - the medication expenses covered in the country of residence, section 6.5.1.
  - the follow up care expenses covered in the country of residence, section 6.5.2.

- Any expenses incurred in connection with or derived from any diagnostic procedures, treatment, service, supply or medical prescription of any nature incurred worldwide when the Insured Party, at the point of the relevant claim notification date, cannot be considered a permanent/legal resident in any of the accepted territories: Denmark, Germany, Sweden or Norway.

- Any expenses incurred outside the applicable Indemnity Period with the exception of those stated under clause 6.5.

- Any expense incurred before the issuance of the preliminary medical certificate.

- Any expense incurred in a different hospital from the authorised and mentioned in the Preliminary Medical Certificate.

- Any expense incurred without following section 5: Claims procedure.

- Any expense incurred in respect of confinement services, health resorts, nature cure clinics, home health care or services provided in a convalescence centre or institution, hospice or old people's home, even where such services are required or necessary as a result of a Covered Disease or medical procedure.

- Any expense incurred in the purchase (or hire) of any type of prosthesis or orthopaedic appliances, corsets, bandages, crutches, artificial members or organs, wigs (even where their use is considered necessary during chemotherapy treatment), orthopaedic footwear, dentures, trusses and other similar equipment or items, with the exception of breast prostheses - after mastectomy surgery - and prosthetic heart valves needed as a result of surgery arranged and paid for by this insurance contract.

- Any expense incurred in the purchase or hire of wheelchairs, special beds, air conditioning appliances, air cleaners and any other similar items or equipment.

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- All medication which has not been dispensed by a licensed pharmacist or which are obtainable without a medical prescription.
- Any charges made for the use of alternative medicine, even where specifically prescribed by a doctor.
- Any charges for medical attention or confinement in cases of cognitive disorders, senility or cerebral impairment, regardless of the status of their development.
- Interpreter's fees, telephone and other charges in respect of items for personal use or which are not of a medical nature, or for any other service provided to relatives, companions or escorts.
- Any expense incurred by the Insured Party or the relatives, companions or escorts, except those expressly covered.
- Any medical expense that is not a customary and reasonable charge.
- Any expenses in respect of accommodation or transportation arranged by the Insured Party, travelling companion or a living donor.

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8. General provisions

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

8.2 Insurance sum
The insurance sum is defined in the insurance contract. The amount stated is per Insured Party. 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.

The insurance is issued for the following maximum amounts unless different amounts are stated in the contract:

Euro 1.000.000 per Insured Party per policy year, however a maximum amount of EUR 2,000,000 per Insured Party in the lifetime of the policy applies.

This annual and lifetime limits include the following sublimits:

- Medication expenses covered after returning from treatment abroad (section 6.5.1): for EUR 50,000 per Insured Party in the lifetime of the insurance.
- Monetary benefits covered during treatment abroad (section 6.4): a payment to the Insured Party subject of the claim of EUR 100 for each overnight stay in a hospital or clinic limited to 60 days per claim.

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

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

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

The due date for payment is indicated on the invoice.

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

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

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

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

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 6 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.

Co-insured

For co-insured family members the insurance will continue until the date for which coverage is paid in cases where the principal insured person leaves the scheme.

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Reimbursement of invoices after termination of the insurance
Invoices for approved treatments and/or transport must always be submitted no later than 180 days 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.

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
When taking out the insurance, the Company will require a medical declaration to be completed for all individuals applying to become an Insured Party. The valid submission of the medical declaration will be necessary for the Company to conduct the appropriate risk assessment and decide positively in favour of issuing the insurance.
The requirement of the medical declaration can only be waived when the insurance is issued as a result of a continuation of insurance request as per the scenario detailed in section 2.3 "Qualifying Provisions".

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The medical declaration can be submitted electronically or orally to the Company. In any case, whether the medical declaration is provided electronically or orally, the Insured Party will receive a confirmation on the medical declaration provided to the Company.

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 or the validity of the medical declaration. 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 or the validity of the medical declaration 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 or the validity of the medical declaration in accordance with §41 of the Health Act regarding the disclosure of health information, etc. in connection with the treatment of patients.

8.9 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.

8.10 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.

8.11 Limitations

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

8.12 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 10 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 complain 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.

8.13 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.

8.14 Right of cancellation

For privately taken out insurance, a right of cancellation applies. This means that the policyholder may cancel a private agreement on insurance in accordance with the rules in Section 34 of the Danish Insurance Contracts Act.

According to the rules under the Danish Insurance Contracts Act, the Policyholder is entitled to receive information on, e.g. the right of cancellation and the service ordered.

If you regret drawing a private insurance, you have a right of cancellation of 14 days. The right of cancellation is calculated from the date on which the agreement was entered into and where you have been informed of the insurance conditions, where the right of cancellation is also described.

If the right of cancellation period expires on a public holiday, Saturday, Constitution Day, Christmas Eve or New Year's Eve, the period does not expire until the following business day.

Before the right of cancellation period expires, you must notify us in writing that you have regretted entering into the agreement. You can let us know by letter or e-mail. The letter or e-mail must be sent before the expiration of the right of cancellation period. For cancellation during the cancellation period, please send a letter to:

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2730 Herlev

or send an e-mail to:
sundhedsforsikring@ds-sundhed.dk