Conditions

Health insurance

Occupational – full-time cover

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Contact Dansk Sundhedssikring

You can reach us by phone at +45 70 20 61 11 or via the user portal on our website: ds-sundhed.dk.

1. Contractual basis

These insurance conditions are valid from 1 January 2026.

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

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

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

The insurance conditions supplement the contract. Special terms and conditions, as well as any deviations from these insurance conditions, must be agreed in writing and be stated in the insurance contract.

The policyholder is obliged to inform its employees/members about what the policy covers, which is stated in the insurance contract with any supplements.

Full-time
The health insurance provides cover in both private and work-related contexts. This means that it covers insured events included in the insurance, regardless of whether the need is work-related or not, unless otherwise stated in the contract.

For co-insured children, an illness, injury or condition is always regarded as leisure-related.

ESG (Environmental, Social and Governance)
Dansk Sundhedssikring takes significant responsibility to ensure that we comply with the requirements set out in the UN Global Compact and uphold our social responsibility in relation to the environment and climate, social matters and corporate conduct (read more about this on our website).

Definitions 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 or company with whom we have entered into the insurance contract.

Children
When the insurance conditions refer to "children", this solely means children who are enrolled in the health insurance, including children covered under a group insurance scheme, unless otherwise stated in the specific cover.

School age
In these insurance conditions, school age is defined as the period during which the child is subject to compulsory education under applicable legislation or is entitled to start school.

Initial diagnosis
In these insurance conditions, when "initial diagnosis" is referred to under "extended psychiatric assessment", it means that the insured must not previously have been diagnosed with ADHD/ADD and subtypes and/or ASD (including all diagnoses within the autism spectrum).

Posting abroad
Posting abroad is understood to mean that an employer in Denmark temporarily sends an employee to work in another country while the employment relationship continues to exist.

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

Musculoskeletal system
In these insurance conditions, musculoskeletal system refers to the large muscle groups, joints, and tendons in the back, neck, shoulders, elbows, wrists, hips, knees and ankles.

Blended care (combined treatment)
In these insurance conditions, blended care is understood as a form of treatment in which physical attendance is combined with digital tools, including online treatment, apps, video calls, emails, chat, digital exercises, digital platforms as well as other comparable or future digital treatment methods.

Chronic diseases/disorders/conditions
Chronic diseases/disorders/conditions are diseases, disorders and conditions that are considered by our doctors to be persistent and cannot be cured and do not go away with treatment, or where there is no curative treatment and/or where there is an ongoing or recurring need for treatment.

General physiotherapy
General physiotherapy (speciality 51), cf. the practice agreement for physiotherapy.

General chiropractic
General chiropractic (speciality 53), cf. the practice agreement for chiropractic.

Network
Our network of therapists in the form of a network of suppliers and therapists with whom we have entered into an agreement.

Intoxicants
This refers to intoxicants covered by the Danish Act on Euphoriant Substances, such as cannabis, heroin and cocaine. Lighter gas, nitrous oxide and similar gases are not included.

Physiotherapy free of charge
Scheme adopted under the Danish Finance Act that provides access to free (without charge) physiotherapy prescribed by a doctor for people with severe physical disabilities and physiotherapy for people without severe physical disabilities but with functional impairment as a result of progressive disease, cf. the Danish Health Authority's guidelines on access to free physiotherapy.

The Danish Health Authority
The highest health authority in Denmark.

The speciality plan
The speciality plan, issued by the Danish Health Authority in accordance with the Danish Health Act, with an overview of which hospitals and private hospitals are allowed to perform so-called speciality functions, such as performing certain operations and examinations.

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?

We offer health insurance and health counselling with a wide range of in-house healthcare competencies and services in one single healthcare centre.

With your health insurance, you receive support, guidance and tools to prevent and treat injuries and to take good care of your health.

Healthcare professionals guide you to the right help, advice or treatment and are ready to help with all types of health problems – even those not covered by the insurance.

The healthcare team provides counselling and treatment based on the latest healthcare and evidence-based knowledge and experience, e.g. assessment of treatment needs, treatment methods, prevention and reduction of overtreatment.

You gain quick access to professional advice, flexible treatment options and digital health solutions such as apps, online treatment and counselling services, training videos and digital courses.

Advice on and prevention of illness, injury and poor well-being is integrated into many of our advisory services to make them more accessible and sustainable.

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 companies registered with a CVR no. in Denmark, and the companies must be located in Denmark, unless otherwise specified in the contract. The insurance covers the employees who are enrolled and named in the insurance contract. The insurance can be taken out for employees or a group of employees as a mandatory or voluntary scheme. There is no upper age limit for employees.

Insured persons must have a permanent registered address in Denmark (excluding Greenland and the Faroe Islands), be entitled to receive Danish public health insurance benefits and have a Danish health card or be permanently residing in the Nordic region or Germany and be entitled to receive benefits equivalent to the public health insurance benefits in the country of residence, unless you are posted abroad.

Special cover can be taken out for contracts where a company has insured employees in Greenland or the Faroe Islands. The cover must be agreed in writing and stated in the insurance contract.

2.1 Enrolment and withdrawal of employees

The company must always notify us on an ongoing basis of which employees it wishes to enrol or withdraw from the insurance scheme. Enrolment and withdrawal can only take place during the current annual period and a maximum of three months back in time. Adjustment in connection with the annual renewal, which triggers a new invoice, may be subject to an administration fee.

The company pays for claims payments that Dansk Sundhedssikring has made for employees who have been withdrawn back in time.

2.2 Co-insured

It is possible to co-insure your spouse/partner/children at a separate price. Children that can be included are your biological and/or adopted children, regardless of their place of residence, and your spouse's/partner's biological and/ or adopted children who have an officially registered address with you. Your spouse's/partner's biological children and/or adopted children who do not have an officially registered address with you can be co-insured if your spouse/partner has taken out voluntary insurance. Children can be co-insured until the age of 24. It is possible to continue cover under a similar scheme until the children reach the age of 27. The insured must always notify us if there are any changes in the relationship that affect who should be covered by the insurance contract.

2.3 Group child cover

If the company has purchased group child cover, your children are automatically and collectively co-insured under the same conditions as you until they reach the age of 24, unless otherwise stated in the insurance cover. If a different age has been agreed for the children, this will be stated in the contract. The children covered are your biological and/or adopted children and your spouse's/partner's biological and/or adopted children, regardless of their place of residence. Foster children can be covered if they have the same officially registered address as the main insured. The group child cover ceases if your cover ceases.

2.4 Waiting period provisions

For mandatory company schemes, there is no waiting period for pre-existing conditions, with the exception of the special provisions for the optional cover "addiction treatment".

For co-insured persons, private customers and voluntary schemes, there is a six-month waiting period for pre-existing diseases and injuries, unless otherwise specified in the individual cover. This means that you must have been covered by the insurance for six months before costs 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.

Seniority from other health insurance can be transferred by direct transfer without delay from other health insurance. This also applies to chronic conditions, unless otherwise specified in the contract.

The insurance offers health counselling and help for all types of health problems – also during the waiting period.

Special provisions apply to the optional cover "extended psychiatric assessment".

For children, the insurance only covers examinations and/or treatment of disorders or needs that have arisen after the child's birth.

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 or the individual option or addition. 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/option.

Based on a medical assessment and after consultation with our doctors, we may in certain cases choose to cover reasonable and relevant examination and/or treatment at a private hospital or at a private specialised medical clinic in the Nordic region, England or the EU, if there is no reasonable place of treatment in Denmark. The treatment must be approved by the Danish Health Authority in Denmark or meet the same quality standards as accredited Danish private hospitals and private clinics. Examination and/or treatment must be in accordance with similar examination and/or treatment used, and which we approve, in Denmark.

It is a condition for cover that the expenses are ordinary and reasonable and, in our assessment, correspond to the level in the country where the treatment takes place.

The choice of treatment centre is made in agreement with us, cf. the provisions in section 5.6 "Examination and treatment by a medical specialist".

If you are resident in the Nordic region or Germany, we cover approved treatment by a physiotherapist, chiropractor or psychologist in the country of residence, unless special provisions apply to the individual cover or the individual option. We cover reimbursement for the treatment corresponding to the Danish amounts/rates. The type of programme will depend on the individual case and the professional judgement of the healthcare team. For example, in a number of cases we can refer you to telephone, online or physical treatment. Other forms of treatment are only covered in Denmark, unless otherwise stated in the contract.

Employees posted abroad

Employees posted abroad and any co-insured persons who are posted together with the employee are only covered for examination and treatment in Denmark, unless otherwise applicable to the agreement/option/addition. Transport costs to and from Denmark are not covered.

During posting or stays abroad, employees and any co-insured persons may be offered access to the digital advisory and health solutions provided by the insurance, based on a professional assessment and in accordance with the applicable provisions for the individual sections.

4. Use of the insurance

The insurance consists of a basic cover and a number of optional extras. The different optional extras are only included if stated in the insurance contract/policy.

The full conditions apply to all covers and optional extras, 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 and documentation

Unless otherwise stated in the individual cover, we can require that you have a doctor's referral or recommendation describing the disease/injury before using the insurance. The doctor's referral must be available before any examination or treatment can begin. You should therefore 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 health-care system. You can use this referral when you report the claim to us.

We can at any time ask you to submit medical records, referrals or certificates that we deem necessary for our medical assessment, including whether the reported condition is covered by the insurance.

For children under the age of two and pregnant women, we may, based on a medical assessment and in relevant cases, require that a doctor has assessed the need for treatment.

4.2 Examination and treatment must be approved

The insurance only covers expenses for examination and/or treatment that we have authorised in advance. It is therefore important that you do not initiate treatment without prior written authorisation. This also applies if there are changes to the treatment agreed with us.

The treatment centre must always be approved by us. If we have not approved the treatment centre, we may refuse cover.

4.3 Emergency treatment is not covered

Emergency treatment of somatic and mental conditions, as well as acute situations, is not covered by the insurance. This includes ambulance services, out-of-hours doctors, accident and emergency situations, suicide attempts, explicit threats of suicide, as well as injuries/conditions that require assistance/examination/diagnostics and/or treatment sooner than the ten-working-day guarantee and/or cannot wait for planned treatment. This applies, for example, to traffic accidents, other accidents, concussion, fall traumas, bone fractures, blood clots/suspected blood clots, cerebral haemorrhage, TCI, heart disease, paralysis, acute sensory disturbances 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 expenses for psychological treatment in the event of acute crisis counselling, cf. the provisions in section 5.8.1 "Emergency crisis counselling".

4.4 Travelling and staying abroad

The insurance does not cover expenses for examination and treatment of disease/injury incurred while travelling or 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.

Travel expenses abroad are not covered, including private expenses such as hotel and companion expenses and companion stays, unless otherwise stated in the individual cover.

Only transport expenses in Denmark are covered, cf. the provisions in section 5.6.9 "Transport expenses".

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 and examinations that have been initiated or planned before the start of this insurance are not covered. This also applies to children covered under a group policy.

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, unless otherwise stated in the contract.

The insurance does not cover examinations and courses of treatment already in progress under a previous insurance company at the time this policy is taken out.

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.

In our judgement, the treatments must be reasonable and necessary and expected to cure the conditions or significantly and permanently improve the state of health.

Treatments of a preventive, supportive, maintenance and palliative nature are not covered, unless otherwise stated in the individual cover. The insurance, however, includes preventive services and counselling aimed at preventing injuries and safeguarding your health.

The insurance covers your actual expenses for examination and treatment after deduction of reimbursement from the National Health Service. This means that in the event that the National Health Service 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 for your treatment.

In cases where we refer you for treatment or examination 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.

Physiotherapy, chiropractic and psychological treatment

You must have a valid referral from your GP for physiotherapy and use a therapist who has an agreement with the National Health Service (provider number), unless otherwise stated in the individual cover.

If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient share according at the rate applicable to general physiotherapy, which is indexed twice a year.

Group exercise training is covered if we consider it relevant as part of the treatment. In cases where we cover group exercise training with a physiotherapist as part of the treatment, group exercise training is covered corresponding to the patient share for group exercise training for general physiotherapy, which is indexed annually.

If the therapist works within the health insurance scheme, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to rehabilitation, network treatment and if you are covered by optional cover B: physiotherapy without a doctor's referral and/or optional cover F: treatment of chronic conditions.

For chiropractic treatment, the amount corresponding to the patient share is covered according to the rate that applies to general chiropractic treatment.

For psychological treatment authorised by a doctor, we cover the patient share of the treatment after reimbursement from the National Health Service. For treatment by a psychologist without an agreement with the National Health Service (provider number), the therapist's fee is covered, up to a maximum of DKK 1,000 per treatment.

If you have a referral from your GP and the therapist works within the National Health Service, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to treatment in our network.

The above provisions apply to the full insurance conditions, including the optional covers under the insurance, but the detailed rules and exclusions are stated in the individual covers.

Other treatment rates are stated in the individual covers.

4.8 Choice of therapist and treatment method

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.

We can offer different types of treatment and counselling options, including digital services. The age limit for telephone and online treatment is 15 years.

We will refer you to an examination and/or treatment provider within our quality-assured network, unless otherwise stated in the contract or in the specific cover. However, for certain types of treatment, you may choose your own practitioner. This is specified under the individual covers. For children, treatment in the network can only be offered by therapists who offer treatment for children.

You cannot choose to switch between treatment with a self-selected practitioner and treatment with a practitioner from our network during the course of a treatment programme. In cases where you have started treatment with a practitioner outside our network, we can decide that treatment must be continued with a practitioner designated by us. This may be the case if you wish to change practitioners or if we assess that the treatment is not having the desired effect.

For treatment in our network, we endeavour to start your treatment within four or five working days and a maximum of ten working days.

For examination and treatment by a specialist, the first examination and/or treatment will be initiated within ten working days in the public or private healthcare system. We will refer you to a therapist/treatment centre. The guarantee of ten working days does not apply to specialists in psychiatry (psychiatrists).

Treatment is covered only if it has been approved by the National Health Service in relation to the public healthcare system and authorised by the public health authorities in Denmark. The treatments must always be carried out using methods with documented effect and be included in the agreement with the National Health Service. The treatment method must always be approved by us and be in accordance with the Danish Health Authority's speciality plan and the national clinical guidelines.

No cover is provided for alternative and/or experimental treatments that are not recognised for the treatment of the disease/disorder in question according to a general medical assessment, or that are not described in the national clinical guidelines and/or are frequently used and/or routinely performed in the public healthcare system.

The insurance does not cover expenses for consultation and/or treatment by general practitioners, specialists in general medicine or equivalent foreign doctors, or experimental and alternative treatments/therapists, such as naturopaths, hypnotists and body therapists or other alternative therapists.

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 we may request 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.

Based on a professional assessment, we can either refuse to cover treatment if the problem cannot be helped or stop a course of treatment if we assess that the treatment is ineffective.

4.10 Reporting a claim

Claims must always be reported during the insurance period. The fastest way to report a claim is to report it online via our website.

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 the user portal on our website.

Emergency crisis counselling

If your claim concerns emergency crisis counselling, you can contact us 24/7 by phone via the main number. 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 covers.

The full insurance conditions apply to all sections, but there are 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 doctors, nurses, physiotherapists and other healthcare professionals have many years of experience from various areas of specialisation and offer 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, concussion, menopause symptoms, diet, lifestyle changes, courses of treatment and management challenges and help with advice on relevant services for cancer patients, counselling groups, inspiration for mental exercises, dietary advice and exercise.

Our nurses and physiotherapists can also provide advice on physical activity and sedentary time for adolescents, adults, elderly people and pregnant women, and how physical activity can relieve many symptoms, and provide access to materials, exercise guidance, exercise videos and an evidence-based exercise app.

We also offer various targeted counselling lines and services, which are described in more detail under the different covers:

- Pregnancy counselling
- Stress prevention and support helpline
- Youth counselling
- Abuse counselling
- Helpline for managers
- Counselling and early intervention in case of risk of long-term illness and cancer
- Online emergency medical service (requires optional cover G: online emergency medical service)
- We can refer you to professional and personalised advice from trained pharmacists and pharmaconomists via chat, email or phone – e.g. on treatment options for menopausal discomfort, smoking cessation, medicines and dietary supplements, discounts on pharmacy products and home delivery from a partner online pharmacy.

Healthcare coordinator

Our healthcare team has in-depth knowledge of both public and private healthcare. Through our unique Health Navigator and coordinator concept, we offer help and guidance related to your treatment 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 guide about 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.

Life stages and working life

The healthcare team can provide advice and/or initiate relevant measures in connection with the various stages of life and working life – for example during pregnancy, in family life, throughout illness or when there is a need for adjustments in your work situation.

The healthcare team can also offer guidance on, or refer to, relevant services provided by the public sector or covered by the health insurance, including for example pregnancy counselling, a preventive stress and wellbeing helpline, youth counselling, a mental toolbox, digital parenting programmes, as well as personalised health programmes for chronic conditions, the menopause and other life stages.

5.2 Pregnancy counselling

The health insurance offers telephone counselling for pregnant women and new parents with a personal pregnancy counsellor. Our pregnancy counsellors all have a relevant health professional background and offer telephone counselling on topics such as pregnancy problems, pregnant at work, the first post- partum period, parenting, abortion, diet, lifestyle, working life, childbirth, relationships, postpartum reactions, postpartum depression, maternity and breastfeeding and the child's well-being and development. Based on the dialogue with you, the pregnancy counsellor will assess whether a follow-up interview is needed.

You can call for counselling every weekday during the current opening hours, which can be found on our website. You call via the main number and access the helpline via the menu. If there is no available pregnancy counsellor, you will be called at an agreed time.

You can also contact the pregnancy counselling service using your computer, tablet or smartphone via the user portal. Here you can write when it suits you best and receive a written response or a call from a pregnancy counsellor at an agreed time.

5.3 Counselling and early intervention in cases of long-term illness and cancer

When you contact the insurance company, the healthcare team can provide guidance and/or initiate interventions in cases of long-term illness, including during and after a cancer course.

The healthcare team offers telephone counselling, support, follow-up and needs assessment and can refer you to relevant health insurance services, such as motivational and supportive conversations, counselling and follow-up by healthcare professionals, tripartite conversations with the stress victim, the helpline for managers with possibility for experienced occupational psychologists, targeted stress management courses and preventive stress and well-being counselling and assessment possibilities.

If stated in the contract, the healthcare team can assess whether there is an increased risk of long-term sickness absence and offer identification and consent-based cooperation and contact with the pension company so that the pension company can advise, clarify needs and initiate measures to reduce the risk of loss of earning capacity.

- **Guidance and interventions during and after cancer**
  The insurance offers support during and after cancer through advice provided by healthcare specialists.

  The healthcare team offers telephone counselling, support and follow-up, including guidance on symptoms and possible treatments for physical late effects of cancer treatment.

  The healthcare team can provide advice on and/or refer you to relevant services in the public healthcare system or under the health insurance, including:

  - Guidance on relevant services for people affected by cancer
  - Support groups
  - Inspiration for mental exercises
  - Nutritional counselling
  - Training and treatment
  - Online medical assistance (requires optional cover G: online emergency medical service)
  - Personal health programmes with access to a dietitian, physiotherapist and psychologist for late effects during and after cancer
  - Examination and treatment abroad (requires the optional cover Cancer Care).

5.4 Chronic diseases

The insurance covers examination and treatment 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 diseases and conditions occurring and/or diagnosed before the insurance period are not covered.

The healthcare team always offers help for all chronic conditions with counselling, 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.

5.5 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.

5.6 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.

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.

Ten-day examination and treatment guarantee

You are guaranteed that a covered examination or treatment is initiated in the private or public healthcare system within ten 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 ten working days will start after we have received and approved the necessary information.

The insurance does not cover examinations/treatment that cannot wait up to ten working days before the first specialist appointment, cf. the provisions in section 4.3 "Emergency treatment is not covered".

If you are already in a public programme or have been referred for examination and/or treatment/surgery in the public hospital system or with a public specialist and you are offered, or can be offered, a public appointment within the ten-working-day guarantee, the need for treatment is not covered by the insurance. In such cases, the public offer must always be activated and/or used.

If you are in an ongoing programme in the public healthcare system and there is a relevant treatment plan and/or if we assess that the public healthcare system has the best options for examination and/or treatment, we may in relevant cases refuse cover in the private sector. We help with counselling and navigation in the further process.

If we assess that it is not possible for you to get an appointment within ten working days in the public healthcare system, including free choice of hospital and activation of the right to rapid assessment and treatment, and that examination or treatment in the private sector is the best solution from a healthcare perspective, 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 therapist designated by us.

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.

Skin conditions

The insurance covers skin conditions that we consider to have a significant impact on your health, such as skin conditions involving severe itching, pain, ulceration, extensive rashes or infections.

Skin diseases that we consider to be cosmetic or chronic are not covered, cf. section 7 "What the insurance does not cover".

We are always happy to provide counselling, navigation in the public system and appointment assistance for all skin conditions.

Skin cancer

If we have covered treatment for skin cancer (for example basal cell carcinoma and squamous cell cancer), and the disease returns, requiring new examinations and/or treatment, the insurance will cover one new assessment and/or treatment within three years of the original onset of the disease.

Asthma and allergy assessment

The insurance covers assessment of suspected asthma or allergies for the purpose of making a diagnosis. It is a condition for cover that your GP is not able to carry out the assessment in his or her practice. The assessment must be approved by us and prescribed by a relevant medical specialist.

The insurance does not cover cases where the GP has recommended or referred the patient for assessment at a public hospital.

The insurance does not cover assessment of previously known asthma/allergies or asthma/allergies where a deterioration is experienced, regardless of the triggering cause.

The insurance does not cover treatment of asthma and/or allergy.

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. 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 opinion, there are serious symptoms, e.g. in the form of wounds that will not heal or deep inflammation, if you have lost your driving licence due to the condition and/or if you are on sick leave.

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 co-operate. 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.

Sleep assessment
The insurance covers assessment of long-term (more than three months) severe physiological sleep disorders that we assess affect your state of health.

The assessment must be prescribed by your GP and approved by Dansk Sundhedssikring's doctor. We will refer you to a treatment centre.

We cover assessment of sleep disorders, e.g. sleep specialist consultation, outpatient examination for sleep apnoea and examination in a sleep laboratory.

In cases where we have covered an assessment, we cover start-up and monitoring of medical treatment of physiological sleep disorders. CPAP treatment is covered for diagnosed sleep apnoea for up to six months from the time of diagnosis.

Bite splints/braces and other similar devices are not covered.

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 or treatment within the guarantee period of ten 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 whatever the reason, e.g. because you want a different treatment centre than the one indicated.
- If you express a wish for assessment or 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 ten 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 performed in the public system, e.g. in the case of special disease diagnoses or complicated diseases, 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, e.g societal actions, IT crashes, hacker attacks, pandemics, epidemics, lockouts and similar – in these cases we are entitled to a reasonable extension of the guarantee.

5.6.1 Follow-up checks

The insurance covers necessary outpatient check-ups after covered surgery for up to 24 months after the last day of treatment. 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.

Post-operative check-ups carried out in the public health sector, or in the private health sector paid for by the public sector, are not covered.

5.6.2 Re-operation

The insurance covers re-operation after a covered operation if the primary operation was performed at a treatment centre designated by us. The re-operation must be prescribed by a specialist and approved by Dansk Sundhedssikring's doctor. We will refer you to a treatment centre.

5.6.3 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.

Third opinion

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.

5.6.4 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.

5.6.5 Temporary assistive devices

The insurance covers reasonable expenses for personal temporary assistive devices that we deem necessary in connection with a covered operation or treatment. The assistive devices 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.

5.6.6 Rehabilitation

The insurance covers reasonable and necessary outpatient rehabilitation with general physiotherapy and chiropractic in direct connection with coverable surgery on the musculoskeletal system. The rehabilitation must be prescribed by the attending specialist.

The insurance covers rehabilitation after surgery in the public sector if the surgery is eligible for cover.

Based on a clinical assessment, the insurance covers doctor-referred rehabilitation for eligible and non-surgery-requiring conditions, e.g. osteoarthritis of the knees and hips, as well as slipped discs in the back, lumbar region and neck without surgery. Conservative treatment by a chiropractor or physiotherapist is covered, including any group exercise training as part of the rehabilitation plan. The aim of rehabilitation is to achieve a self-training level.

Treatment can take place in our network or with a therapist of your choice.

Reimbursement and subsidies

You must have a valid doctor's referral for physiotherapy and use a therapist who has an agreement with the National Health Service. We cover the patient share of the treatment after reimbursement from the National Health Service. If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient share at the rate applicable to general physiotherapy, which is indexed twice a year. Group exercise training with a physiotherapist is covered if it is part of a covered rehabilitation programme and is approved by us. Group exercise training is covered corresponding to the patient share for group exercise training, which is indexed annually. For chiropractic care, the amount corresponding to the patient share is covered at the rate that applies to general chiropractic care (indexed annually).

The insurance does not cover other forms of rehabilitation.

Recreation and treatment stays are not covered (recreation is covered based on the provisions in section 5.6.7 "Recreation").

Rehabilitation in Dansk Sundhedssikring's 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 clinic, and we settle directly with the therapist.

Rehabilitation outside Dansk Sundhedssikring's network

The insurance covers the necessary number of treatments with a therapist of your choice based on a professional assessment. Treatments are allocated in portions. If more treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments. As part of our assessment, we may ask for a status report, a rehabilitation plan or a treatment plan from your therapist.

You pay the therapist yourself. When your course of treatment is complete, you must submit a copy of all original bills.

5.6.7 Convalescent care

The insurance covers expenses for authorised convalescent care in Denmark in direct continuation of surgery or hospitalisation or cancer treatment abroad covered by the insurance.

Reasonable and necessary expenses are covered, up to a maximum of DKK 75,000.

Convalescent care must be prescribed in writing by the attending specialist and Dansk Sundheds-sikring's doctor. We may ask for a treatment plan to be sent to us. We will refer you to a treatment centre in our quality-assured network.

No reimbursement is provided for holiday-like stays, stress relief or similar.

Convalescent care due to mental disorders are not covered.

A maximum of DKK 75,000 per insured can be covered for convalescent care during the entire insurance period.

5.6.8 Home help/home nurse

The insurance covers reasonable and necessary expenses for temporary help at home in direct continuation of a covered operation – or cancer treatment abroad - 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 six months from the date of discharge. Home help is not covered in cases where the need can be attributed to old age, dementia, senility or similar. We can choose to have the service provided by a home service company designated by us.

5.6.9 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. Expenses are not covered for transport to a specialist in psychiatry, in connection with acute crisis help, hospice and terminal care or in connection with the optional cover "addiction treatment". Taxi fares are not covered. Transport expenses for specialised medical care abroad 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 and 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 60 kilometres from your place of residence. Cover is provided at the state's lowest rate for driving your own car or the cheapest form of public transport.

Patient transport (recumbent)

The insurance covers recumbent patient transport between home and hospitalisation/operation that is eligible for cover. 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

From your first contact with the insurance company, the healthcare team can offer counselling and support to deal with physical challenges – whether they are covered by the insurance or not.

To ensure optimal prevention, counselling and treatment of your problem, we may, based on a professional assessment, refer you to various forms of counselling and treatment and/or self-training, e.g. exercise counselling, exercise videos, exercise apps, online physiotherapy, physiotherapy and chiropractic with physical attendance or a combination of digital treatment and physical attendance.

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

Exercise app
Based on a health professional assessment, we can give you up to six months access to an exercise app that offers rehabilitation and prevention of pain throughout the body based on specially designed exercise programmes.

Get off to a good start – fast help for new and uncomplicated musculoskeletal pain in the musculoskeletal system
The healthcare team offers quick clarification of treatment needs, advice and guidance on exercises to manage your own pain, follow-up, care calls and access to an evidence-based training app based on the latest healthcare knowledge by experienced nurses and physiotherapists.

The physical toolbox
We offer quarterly online courses for managers and HR to support pain management in the workplace. The course focuses on and provides knowledge about pain and how managers and organisations can support employees with pain and effectively prevent pain issues. The courses are held by a pain physician or a specially trained physiotherapist and are held in both Danish and English.

We also offer tailored solutions to companies where several employees experience the same pain-related issues. In collaboration with our quality-assured network of partners, we can tailor a range of services to help manage pain in the workplace.

Physiotherapist and chiropractor
The insurance covers reasonable and necessary treatment in Denmark following a referral from the healthcare team. It is a prerequisite for cover that there is a medically documented need for treatment.

In our judgement, the treatments must ensure progression and lead to a significant and lasting improvement of the condition.

Following a professional assessment, we may either refuse to cover treatment of a recurring condition/problem, or stop a course of treatment if the treatment is deemed to be ineffective.

Physical disorders that, in our judgement, cannot be cured or significantly and permanently improved are not covered.

Treatment can take place in our network or with a therapist of your choice.

You must always have a valid doctor's referral for physiotherapy, and the physiotherapist or chiropractor must have an agreement with the National Health Service (provider number). We cover the patient share after reimbursement from the National Health Service. If you choose a therapist without an agreement, the insurance covers the amount corresponding to the patient share at the rate applicable to general physiotherapy, which is indexed twice a year. Group exercise training with a physiotherapist is covered if it is part of a covered course of treatment and is approved by us. Group exercise training is covered corresponding to the patient share for group exercise training, which is indexed annually.

For chiropractic, the amount corresponding to the patient share is covered at the rate that applies to general chiropractic (indexed annually).

Online physiotherapy and blended care (combined treatment)
In relevant cases, we may refer you to a targeted programme with a physiotherapist, with whom we collaborate. Based on a professional assessment and in consultation with you, the programme can be purely digital in the form of video consultations with the physiotherapist or as blended care – a combination of digital treatment and physical attendance. The programme includes the option of a chat function between consultations and free access to a digital training platform.

In relevant cases, we may refer you to a targeted programme with a chiropractor, with whom we collaborate. The programme combines digital treatment and physical attendance (blended care).

The length of the programme depends on a professional assessment. You are offered a quick appointment with a quality-assured partner, and we settle directly with the therapist.

Treatment in Dansk Sundhedssikring's 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.

Treatment outside Dansk Sundhedssikring's network
The insurance covers the necessary number of treatments with a physiotherapist or chiropractor of your choice. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments.

As part of our assessment, we may ask for a medical assessment or a written justification for continued treatment from the physiotherapist or chiropractor. You pay the therapist yourself.

When your course of treatment is complete, you must submit a copy of all original bills.

In cases where you have started treatment with a therapist outside our network, we can decide that treatment must be continued with a therapist designated by us. This may be the case if you wish to change therapists or if we assess that the treatment is not having the desired effect.

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 doctor 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 and is determined 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.

5.8 Mental health

Already at your first contact with the insurance company, the healthcare team can, based on a professional assessment, offer counselling and support to deal with mental challenges – regardless of whether they are covered by the insurance or not.

In cases where we assess that you need treatment – for example if you have a reduced ability to function in everyday life or symptoms that require treatment, cf. the provisions in section "Treatment with a psychologist and psychotherapist"and in section 1.2 "What does the insurance cover?" – the insurance covers reasonable and necessary treatment. It is a prerequisite for cover that the injury is eligible for cover.

We can offer counselling for stress, well-being and life change challenges and refer you to a variety of treatment options, including telephone, online or face-to-face treatment, as well as a specialised treatment product for children. The type of programme will depend on the individual case and the professional judgement of the healthcare team. The details are set out in the individual sections.

In cases where our medical assessment is that assessment and/or treatment can best be carried out in the public sector, we can refer to public services to be activated and used. This may be the case, for example, 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 or for assessment and treatment of suspected serious mental illness. 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.

Stress prevention and support helpline

When you have health insurance with Dansk Sundhedssikring, you can call for personalised and fast counselling and support for stress- or well-being-related problems that do not require actual treatment.

The stress prevention and support helpline is staffed by an experienced in-house counselling team, all of whom have relevant healthcare backgrounds and can help you prevent and deal with problems before they become serious.

Here you can get fast and personalised counselling and help to strengthen your mental health – already at the early signs of stress and well-being issues. Counselling is provided on for example:

- Reducing and preventing early signs of stress and unhappiness.
- Private well-being issues, such as personal crises, grief, children, relationships, divorce, lifestyle and substance abuse.
- Work-related well-being issues, such as burnout, dismissal, bullying and conflicts.

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

As part of the stress and well-being line, we also offer:

- **Youth counselling**
  Counselling for enrolled young people (16-27 years) in the form of confidential conversations with healthcare professionals about challenges such as stress, anxiety, loneliness, chronic illness, eating problems or low self-esteem or problems in the family, school or with friends.

- **Addiction counselling**
  Confidential conversations in the form of counselling and guidance on substance abuse problems by healthcare professionals, including counselling about addiction or treatment for different types of addiction (e.g. alcohol, cocaine, cannabis, drugs), compulsive gambling and compulsive buying, sex and pornography addiction, and gaming disorder or about the challenges of being related to or close to someone with addiction problems. Substance abuse disorders of any kind are not covered by the basic insurance. Substance abuse treatment is covered based on the special provisions for the optional cover "Optional cover C: substance abuse treatment" if the cover has been purchased.

You can call the stress- and wellbeing helpline on weekdays during the current opening hours, which can be found on our website. You call via the main number and access the helpline via the menu. If there is no available counsellor, you will be called at an agreed time.

You can also contact the counselling service using your computer, tablet or smartphone via the user portal. Here you can write when it suits you best and receive a written response or a call from a counsellor at an agreed time.

Helpline for managers

The helpline for managers is an offer for HR and managers and provides access to telephone counselling where you as a manager can get help to explore new perspectives or explore your options for action if, for example, you have employees with stress, employees with illness, employees with personal challenges that affect their work, well-being issues, bullying, conflicts, or if an accident or violent incident has occurred in the workplace.

Through the helpline for managers, we can provide HR and managers access to relevant material on hormonal changes and working life, how to have an open dialogue and actively create the framework for a flexible and supportive work environment that accommodates menopausal employees, and we offer the opportunity to purchase external lectures and workshops with experts we collaborate with.

The helpline for managers is staffed by our internal mental health team, all of whom have relevant professional backgrounds. Based on the dialogue with you, the team will assess whether there is a need for follow-up sessions.

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

You can call the helpline for managers on weekdays during the current opening hours, which can be found on our website. You call via the main number and access the helpline via the menu. If there is no available counsellor, you will be called at an agreed time.

You call via the main number and access the helpline via the menu. If there is no available counsellor, you will be called at an agreed time. You can also contact the counselling service using your computer, tablet or smartphone via the user portal. Here you can write when it suits you best and receive a written response or a call from a counsellor at an agreed time.

Access to mental health app and mindfulness for children, young people and parents

Based on a health professional assessment, we can give you six months' access to a mental health app. The app is based on cognitive behavioural therapy and teaches children aged 8 to 16 and their parents how to deal with difficult emotions and topics such as grief, bullying, shyness, divorce, social anxiety, sleep problems, gaming addiction and mindfulness for children and adults.

The insured's children are covered under this benefit, regardless of whether they are co-insured or not.

Digital ADHD/ADD counselling by a psychiatrist and specially trained psychologist
You get access to a digital learning platform with self-help in the form of useful knowledge and guidance on ADHD/ADD. The platform was developed by specialists in psychiatry and psychology and can also be used by carers. You must be 18 years or older to use the platform.

The mental toolbox
We offer a range of programmes that provide insight into how a healthy mind responds to pressure, along with practical tools that enable you to take action yourself and strengthen your mental well-being. The focus is on functional ability and actions tailored to your situation and experiences.

Based on a professional assessment, the healthcare team may offer access to a variety of targeted services:

- **Mental health – your toolbox**
  Live webinars with psychologists/psychotherapists, where you gain insight into how to handle pressure, for example major life changes. You have the opportunity to ask questions during the session. You will gain knowledge about the mind's reactions and get practical tools that you can use in the future to strengthen your mental health.

- **Mental health – your toolbox with a mentor**
  Personalised conversations with an experienced mentor targeted at life challenges where you need extra support to work with tools that strengthen your mental health.

- **Mental health – your toolbox as a manager/HR: "Empower employee mental health"**
  Live webinars for managers and HR focusing on employee reactions to life challenges and stresses. The webinar will explain normal and healthy reactions to stress and how managers/HR can prevent deterioration and support and help employees – and when there are conditions and reactions that require professional help and treatment. The webinar is interactive and participants can contribute with their own experiences and challenges and get feedback from the healthcare trainers.

Treatment with a psychologist and psychotherapist
Based on a professional assessment of the need for treatment, the insurance covers relevant, reasonable and necessary individual treatment/therapy for mental disorders and mental challenges requiring treatment by a qualified clinical psychologist (with accredited clinical training) or a psychotherapist.

Treatment can take place in our network or with a therapist of your choice. Treatment by a psychotherapist is only offered in our network.

It is a prerequisite for cover that there is a medically documented need for treatment and that there are symptoms requiring treatment/impaired ability to function in everyday life.

In our judgement, the treatments must ensure progression and lead to a significant and lasting improvement of the condition, and we may refuse to cover treatment of a recurring disorder/problem following a professional assessment.

Mental disorders that, in our judgement, cannot be cured or significantly and permanently improved are not covered.

The healthcare team will refer you for treatment and will continuously assess how many sessions you need and whether you are receiving the right treatment.

We will assess whether you may need to submit a valid doctor's referral or a medical recommendation. Stress does not require a doctor's referral/recommendation. Based on a professional assessment, the team can refer you to various forms of stress prevention, counselling and treatment.

If you have a referral from your GP and the therapist works within the National Health Service, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to treatment in our network. For psychological treatment prescribed by a doctor, we cover the patient share of the treatment after reimbursement from the National Health Service. For treatment by a psychologist without an agreement with the National Health Service (provider number), the therapist's fee is covered, up to a maximum of DKK 1,000 per treatment.

Treatment in Dansk Sundhedssikring's 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 psychologist or psychotherapist, and we settle directly with the therapist. Based on a professional assessment, we can refer you to different types of treatment:

- **Telephone programmes**
  We can refer you to telephone counselling with experienced psychotherapists and psychologists.

- **Online courses of treatment**
  We can refer you to video consultations with experienced psychotherapists and psychologists. As part of the programme, you get access to an online library of exercises and knowledge about mental health.

- **Stress management programmes**
  We offer various forms of treatment for stress, and the healthcare team can advise on the different options. In relevant cases – and based on a professional assessment – the team can, for example, refer to specific targeted stress management programmes. The programme is tailored to the individual and can include access to written material and tools for working with stress as well as telephone and/or online therapy with video consultations.

- **Face-to-face programmes**
  We can refer you to face-to-face programmes with experienced psychotherapists and psychologists.

- **Digital parenting programmes**
  We can refer you to specially designed digital programmes for parents with children aged 0–18 and enrolled in the health insurance, including children covered under a group policy. The programmes are delivered by psychologists, psychotherapists and specially trained nurses with particular experience in families, children/young people and parental support. The child is the focal point of the treatment, but the parents are the main focus and take an active role in supporting the child's mental health. The aim is to strengthen the parents and the family dynamics in order to provide the best possible support for the child. The child may be included in the sessions if the practitioner considers it relevant.

- **Specialised treatment product for children with mental health problems**
  We can refer you to specially designed courses of treatment for children under the age of 15 and their parents. The courses of treatment are run by psychologists with specialised experience in the field and involve parents in the treatment to a high degree. Involving parents increases their contribution to the therapeutic alliance and strengthens their ability to help the child – even after treatment has ended. In relevant cases, a written handover of relevant information can be made and shared with, for example, the municipality, Educational Psychological Counselling (PPR), day care, school, psychiatry or caseworker so that they are able to provide the right support.

- **Tripartite counselling in case of work-related stress**
  In case of work-related stress, we can, based on a professional assessment and in consultation with you, refer you to tripartite counselling between you, your manager (or HR) and a psychologist. We will find you a psychologist with specialised experience in stress and stress management in the workplace. The programme focuses on the labour market situation, e.g. when there is a need to help with retention or return to work. The programme is not preventive in nature and does not address issues other than stress. The programme is therefore not suitable in cases of long-term stress reactions or medical treatment or in cases of severe stress with long-term sick leave.

Treatment outside Dansk Sundhedssikring's network

The insurance covers the necessary number of treatments with a psychologist of your choice for up to six months per disease/claim with effect from the first day of treatment. Children under the age of 18 are covered for a maximum of five treatments per calendar year – even in the event of multiple claims. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess whether more treatments can be authorised.

As part of our assessment, we may ask for a medical assessment or a written justification for continued treatment from the psychologist. You pay the therapist yourself. When your course of treatment is complete, you must submit a copy of all original bills.

In cases where you have started treatment with a practitioner outside our network, we can decide that treatment must be continued with a therapist designated by us. This may be the case if you wish to change therapists or if we assess that the treatment is not having the desired effect.

For children under the age of 18 treatment in our network cannot be covered if the treatment has started with a psychologist of your choice.

The Cool Kids and Chilled anxiety treatment programmes for children
If your child has been referred by a GP to psychological treatment of anxiety disorders arising during the insurance period, we can, based on a professional assessment and in consultation with you, refer children to the Cool Kids anxiety treatment programme for children aged 7-12 years and the Chilled programme for children aged 13-17 years.

The programmes are offered as group programmes for children/young people and their parents or, in some cases, as individual programmes. The programmes begin with an individual preliminary interview with a psychologist to determine if the child is in the target group.

The length of the programme depends on a professional assessment. One anxiety programme is covered during the insurance period. We consider the programme to be completed if you choose to discontinue treatment prematurely.

In cases where we do not cover the anxiety programme – for example if the psychologist assesses that the programme is not relevant – the cover for ordinary psychological help will apply.

Psychiatrist
The insurance covers reasonable and necessary GP-referred consultations with a psychiatrist regarding a covered injury/disorder. In our judgement, the consultations must ensure progression and lead to a significant and lasting improvement of the condition. We may refuse further cover if we have previously covered the same illness/injury/disorder.

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.

5.8.1 Emergency crisis counselling
You can always call the healthcare team for advice in cases of acute and traumatic incidents.

The healthcare team may refer you to a range of different treatment options if we assess that you are experiencing an acute psychological crisis requiring treatment due to the following:

- If you are exposed to a sudden, serious incident/accident where you have been 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 – or an incident of a similar nature, regardless of whether it involves a colleague, a family member or another individual.

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 will assess which type of treatment is needed and may refer you to different forms of care:

- In relevant cases, and based on a professional assessment, we may refer you for treatment with a psychologist or psychotherapist – either by telephone, online or in person within our network of practitioners.
- If we assess that you are entitled to crisis support and the incident requires an urgent response, you may be offered telephone contact with a psychologist in our network within three hours after the claim has been approved, depending on the nature of the incident and its geographical location. Any subsequent course of treatment will be determined based on a professional assessment.

If the claim is reported more than 48 hours after the incident, or if the healthcare team assesses that the incident does not entitle you to acute crisis support, the cover for standard psychological treatment will apply, cf. the provisions in section 5.8 "Mental health".

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

Based on professional judgement, we may choose to cover debriefing in the form of one session with a psychologist at the workplace if there has been a serious work accident or other violent/traumatic incident where several employees have been involved in or witnessed the incident and need help.

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

It is possible to purchase additional debriefing sessions for groups. When purchasing additional sessions, the effort is coordinated with the workplace.

Emergency psychological treatment or debriefing abroad is not covered.

5.9 Hospice and terminal care

The insurance covers an authorised stay at a Danish hospice in connection with a terminal diagnosis made during the insurance period for up to three months, up to a maximum of DKK 100,000.

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

Alternatively, we can authorise terminal care at home by a home nurse for up to three months, up to a maximum of DKK 100,000.

A maximum of DKK 100,000 in hospice or terminal care expenses can be covered for the entire insurance period. We may choose to use a hospice or a provider designated by us.

5.10 Dental treatment

The insurance covers dental treatment prescribed by a specialist when damage to the teeth has occurred in direct connection with the treatment of a covered injury where the treatment was initiated by us. Reasonable and necessary expenses are covered, up to a maximum of DKK 20,000 per claim.

5.11 Personalised health programmes

Based on a professional assessment, we may refer you to personal digital health programmes in the form of individually adapted programmes. The health programmes are offered by an experienced provider in our quality-assured network. The duration and content of the programmes are based on the therapist's professional assessment and have a maximum duration of 12 months.

The programmes are covered regardless of whether the disorder occurred before or during the insurance period. A maximum of one programme per disorder can be covered during the insurance period. We consider a course of treatment to be completed if you choose to discontinue treatment prematurely.

Based on a professional assessment, we may refuse to cover a personal health programme if we have previously covered treatment by a dietician for the same condition/problem, cf. section 6.1 "Dietician".

You must be 16 years or older to use the programmes.

- **Personalised health programme for the treatment of diabetes, COPD, osteoporosis, hypertension, cardiovascular disease, osteoporosis, multiple diseases and obesity**
  If you have been diagnosed with diabetes, COPD, hypertension, cardiovascular disease, osteoporosis, multiple diseases (defined as at least two diagnosed chronic conditions), or obesity (BMI of 30 and above), we can refer you to a personalised digital health programme for lifestyle and chronic disease management based on a professional assessment. You will have access to an individualised programme with digital health coaching, counselling and tailored health plans from an experienced clinical dietitian. Based on a professional assessment, the programme can be combined with digital personal counselling about physical and mental health and well-being from a psychologist and/or physiotherapist.

- **Personalised health programme for overweight pregnant women**
  If you are overweight during pregnancy (a BMI of 30 or more at the start of pregnancy), we can refer you to a programme of up to 12 months with targeted information and advice on overweight, diet and exercise during pregnancy, including recommendations and options for action. The programme includes dietary advice and lifestyle intervention by an experienced clinical dietitian during pregnancy and in the early postnatal period and can be combined with personal counselling from a psychologist and/or digital training and exercise advice from a physiotherapist.

- **Personalised health programme - Men's and women's health**
  For severe and persistent physical and psychological symptoms that negatively affect your everyday life and quality of life, such as cognitive changes, difficulty sleeping, mood changes, decreased energy and fatigue, weight gain, troublesome hot flashes, dry mucous membranes and joint and muscle pain, we can refer you to a programme with initial online screening, text and video consultations and help to manage severe symptoms and improve your daily life with the help of a treatment team consisting of a dietitian, physiotherapist and psychologist and access to articles and videos. The team can, for example, help with counselling and management of physical and psychological symptoms, reduced energy, treatment of menopausal symptoms, transitions in life and targeted prevention, hormone therapy, hormonal symptoms, decrease in testosterone levels, aging processes, sleep, loneliness, lifestyle changes, diet and good habits.

- **Personalised health programme for managing life after cancer**
  If you experience severe and lasting discomfort during cancer or severe and lasting sequala after cancer in the form of physical and mental health problems that affect your everyday life, such as sleep problems, bowel problems, pain and anxiety, we can, based on a professional assessment, refer you to a personalised digital health programme for managing life with and after cancer. You will have access to an individually tailored programme for managing symptoms, sequelae, every day and social life, nutrition, exercise and tools for coping with life with and after cancer. You will have access to digital health coaching, counselling and tailored health plans from an experienced clinical dietitian. Based on a professional assessment, the programme can be combined with digital personal counselling from a nurse, physiotherapist and/or psychologist.

5.12 Examination and treatment abroad – Cancer Care (additional cover)

Cancer Care is an additional cover to the basic cover. You are covered by Cancer Care if it is stated in the insurance contract.

For the Cancer Care cover, please see Appendix 1: personalised medicine and cancer treatment abroad to be found on our website.

In the event of disagreement about the choice of treatment/treatment plan and if the treatment can be carried out in your home country, the attending specialist in your home country will always decide which treatment can be offered. The treatment will take place in the home country.

In the event of any discrepancy between the Danish and English versions of Appendix 1, the English text will prevail at all times. The English appendix can be found on our website.

6. Optional covers

This section concerns covers that can be purchased as add-ons to the health insurance. You should therefore be aware that the various optional covers only apply if they are stated in the insurance contract/policy.

All these covers are subject to the full insurance conditions, but also to the more detailed rules and exclusions set out under each individual cover.

6.1 Optional cover A: acupuncture, reflexology, osteopathy and dietician

The cover only applies if it is stated in the insurance contract.

This option covers treatment by an acupuncturist, reflexologist, osteopath or dietician following a referral from the healthcare team. You can choose which therapist to use. If you wish, the healthcare team can help you find a therapist. Treatment is covered in Denmark.

Treatments must be performed by a reflexologist or acupuncturist registered under the RAB scheme, authorised osteopath or authorised clinical dietician. You pay the therapist yourself. When your course of treatment is completed, you must submit a copy of all original bills.

Acupuncture

Acupuncture treatment is covered for eligible musculoskeletal disorders. Cover is provided for the number of reasonable and necessary treatments for which there is a medical justification, with a maximum of ten treatments per disease/injury and a maximum of ten treatments per calendar year.

In our judgement, the treatments must lead to a significant and lasting improvement of the condition, and we may refuse to cover treatment of a recurring disorder/problem based on a professional assessment. The treatments are allocated in portions, and we will continuously assess how many treatments are needed. The insurance covers the therapist's fee, up to a maximum of DKK 500 per session.

Reflexology

Reflexology is covered for eligible musculoskeletal disorders. Cover is provided for the number of reasonable and necessary treatments for which there is a medical justification, with a maximum of ten treatments per disease/injury and a maximum of ten treatments per calendar year.

In our judgement, the treatments must lead to a significant and lasting improvement of the condition, and we may refuse to cover treatment of a recurring disorder/problem based on a professional assessment. The treatments are allocated in portions, and the healthcare team will continuously assess how many treatments are needed. The insurance covers the therapist's fee, up to a maximum of DKK 500 per session.

Osteopathy

Osteopathy is covered for eligible musculoskeletal disorders. Cover is provided for the number of reasonable and necessary treatments for which there is a medical justification, with a maximum of ten treatments per disease/injury and a maximum of ten treatments per calendar year.

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

Dietician

Cover is provided for treatment by an authorised clinical dietician. Cover is provided for the number of necessary treatments for which there is a medical justification, with a maximum of ten treatments per disease/injury and a maximum of ten treatments per calendar year.

We assess whether you may need to submit a medical recommendation.

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

We also offer online dietitian consultations with a partner in our network. Treatments are allocated in portions. You are offered a quick appointment with a quality-assured dietician, and we settle directly with the therapist.

If you are diagnosed with diabetes, high cholesterol, cardiovascular disease, bowel disorder, gout, endometriosis, coeliac disease, PCO/PCOS or a metabolic disorder requiring treatment during the insurance period, or if you are medically assessed to be underweight and such underweight requires treatment and poses a risk to your health, one course of treatment (maximum ten treatments) can be covered during the insurance period.

The insurance does not cover dietician treatment in connection with desired pregnancy, breastfeeding, underweight, sports nutrition, food allergies, intolerance and similar conditions, as well as mental disorders – including stress, depression, eating disorders and overeating. Based on a health professional assessment the insurance covers treatment by a dietician for obesity during pregnancy and postpartum weight requiring treatment.

In our judgement, the treatments must lead to a significant and lasting improvement of the condition, and we may refuse to cover treatment of a recurring disorder/problem based on a professional assessment. We may refuse to cover treatment by a dietician if we have previously covered a personal health programme for the same condition/problem, cf. section 5.11 "Personal health programmes".

6.2 Optional cover B: physiotherapy without the need for a doctor's referral

The cover only applies if it is stated in the insurance contract.

With this cover, there is no requirement for a doctor's referral for physiotherapy.

If we deem that there are medical reasons for treatment, the healthcare team can refer you directly to treatment.

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

The insurance covers reasonable and necessary treatment. Treatment can take place in our network or with a therapist of your choice.

In our judgement, the treatments must ensure progression and lead to a significant and lasting improvement of the condition. Following a professional assessment, we may either refuse to cover treatment of a recurring condition/problem, or stop a course of treatment if the treatment is deemed to be ineffective.

Physical disorders that, in our judgement, cannot be cured or significantly and permanently improved are not covered.

If you have a referral from your GP and the therapist works within the National Health Service, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to treatment in our network. If you choose a therapist without an agreement, the insurance covers the therapist's fee, up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the indexed rates in the agreement. Group exercise training with a physiotherapist is covered if it is part of a covered course of treatment and is approved by us. Group exercise training is covered corresponding to the full fee for group exercise training, which is indexed annually.

Online physiotherapy and blended care (combined treatment)

In relevant cases, we may refer you to a targeted programme with a physiotherapist, with whom we collaborate. Based on a professional assessment and in consultation with you, the programme can be purely digital in the form of video consultations with the physiotherapist or as blended care – a combination of digital treatment and physical attendance. The programme includes the option of a chat function between consultations and free access to a digital training platform.

The length of the programme depends on a professional assessment. You are offered a quick appointment with a quality-assured partner, and we settle directly with the therapist.

Treatment in Dansk Sundhedssikring's 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 clinic, and we settle directly with the therapist.

Treatment outside Dansk Sundhedssikring's network

The insurance covers the necessary number of treatments with a physiotherapist of your choice. Treatments are allocated in portions. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments. As part of our assessment, we may ask for a medical assessment or a written justification for continued treatment from the physiotherapist. You pay the therapist yourself. When your course of treatment is complete, you must submit a copy of all original bills.

6.3 Optional cover C: addiction treatment

The cover only applies if it is stated in the insurance contract.

This option covers reasonable expenses for treatment for abuse of and addiction to:

- Alcohol
- Prescription medicine
- Drugs covered by the Danish Act on Euphoriant Substances
- Diagnosed gambling addiction (compulsive gambling).

No other forms of abuse than those mentioned above are covered.

You can only be covered for "addiction treatment" once you have been covered by the insurance for six months. It is possible to transfer seniority in connection with direct transfer from another company where you also had similar cover.

Doctor's referral

The treatment must be prescribed in writing by a general therapist, and, in our judgement, there must be a realistic possibility of recovery.

Treatment must be authorised

Treatment must not be initiated without our prior authorisation. Based on a professional assessment, we will refer you for outpatient or inpatient treatment at a treatment centre in Denmark designated by us.

Previous treatment

The insurance does not cover if we assess that you have previously been treated for the same type of addiction. By previous treatment, we mean:

- Outpatient and/or online treatment programmes of at least three weeks' duration
- Antabuse treatment combined with talk therapy provided by the patient's GP of at least three weeks' duration
- Inpatient treatment programmes at a public or private treatment facility of at least one week's duration
- Treatment by a psychologist for gambling addiction/compulsive gambling
- Other comparable treatments.

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

A maximum of up to a total of DKK 100,000 per insured person can be covered for the entire insurance period, regardless of whether there are several different forms of addiction.

6.4 Optional cover E: private hospital cover

The cover only applies if it is stated in the insurance contract.

The option covers reasonable and necessary examination and treatment of a covered disease/injury performed by a relevant specialist at a hospital or clinic.

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.

Doctor's referral

You must always have a valid referral from your doctor. If your doctor assesses that you need examination or treatment, you must 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.

Ten-day examination and treatment guarantee

You are guaranteed that a covered examination or treatment is initiated in the private or public healthcare system within ten 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 ten working days start after we have received and approved the necessary information.

If we assess that the treatment can appropriately take place at a private treatment centre in our quality-assured network, this optional cover allows you to choose a private treatment centre. We will refer you to a private clinic or hospital in our nationwide network. You must always use the therapist designated by us.

The insurance does not cover examinations/treatment that cannot wait up to ten working days before the first specialist appointment, cf. the provisions in section 4.3 "Emergency treatment is not covered".

If you are in an ongoing programme in the public healthcare system and there is a relevant treatment plan and/or if we assess that the public healthcare system has the best options for examination and/or treatment, we may in relevant cases recommend that you continue in the public programme. We help with counselling and navigation in the further process.

The examination and treatment guarantee does not cover:

- If you completely or partially reject an offer of examination and/or treatment in the private healthcare system whatever the reason, 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 ten 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 or complicated disease developments, or if you are undergoing a long-term assessment or treatment 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, e.g. societal actions, IT crashes, hacker attacks, pandemics, epidemics, lockouts and similar – in these cases we are entitled to a reasonable extension of the guarantee.

6.5 Optional cover F: treatment of chronic conditions

The cover only applies if it is stated in the insurance contract.

The option covers treatment of chronic/persistent disorders. Cover is provided regardless of whether the disorder occurred before or during the insurance period.

However, for co-insured family members with an applicable waiting period, conditions that have arisen and/or been diagnosed before the start of the insurance period will not be covered until after the end of the waiting period. Group child cover does not have a waiting period.

Treatment with a physiotherapist, chiropractor, physiurgical massage therapist, podiatrist and psychological help is covered after referral from the healthcare team.

The treatment must be medically justified, and we will assess whether you need a written recommendation from a doctor. However, you must always have a valid doctor's referral for podiatry.

We may refuse to cover treatment of recurring disorders/relapses if the treatment is deemed ineffective and/or we have previously covered treatment of the same problem for this option.

Treatment of musculoskeletal disorders by physiotherapists, chiropractors and physiotherapists

The option covers reasonable and necessary treatment of diagnosed or long-term (more than six months) osteoarthritis or other chronic musculoskeletal disorders with up to a total of 12 physiotherapy, chiropractic or massage treatments per calendar year. Of the 12 treatments per calendar year, a maximum of four of them may be physiotherapy massage and a maximum of four of them may be shockwave treatment performed by a physiotherapist or chiropractor.

Based on a medical assessment, we may choose to cover shockwave therapy (ESWT) performed by a physiotherapist or chiropractor for diagnosed long-term (more than three months) symptoms of tennis elbow, Achilles tendonitis, heel spurs and shoulder tendinopathy – or as an alternative to surgery for non-union (non-healing of bone fractures). A maximum of one shockwave authorisation per problem can be covered during the insurance period.

Palliative treatments are covered.

You can choose which therapist to use. If you wish, the healthcare team can help you find a practitioner in our quality-assured network.

Treatments are allocated in portions, and the healthcare team will continuously assess how many treatments are needed. If additional treatments are needed, you must contact the healthcare team, who will assess and authorise more treatments. As part of our assessment, we may ask for a medical assessment or a written justification for continued treatment from the physiotherapist or the chiropractor.

Treatment of diagnosed headache disorders, such as migraine, Horton's headache and post-traumatic headache, is not covered under this option.

Online physiotherapy and blended care (combined treatment)
In relevant cases, we may refer you to a targeted programme with a physiotherapist, with whom we collaborate. Based on a professional assessment and in consultation with you, the programme can be purely digital in the form of video consultations with the physiotherapist or as blended care – a combination of digital treatment and physical attendance. The programme includes the option of a chat function between consultations and free access to a digital training platform.

In relevant cases, we may refer you to a targeted programme with a chiropractor, with whom we collaborate. The programme combines digital treatment and physical attendance (blended care).

The number of treatments depends on a clinical assessment and is included in the overall limit of a maximum of 12 treatments – both within and outside the network – per calendar year, counted from the first day of treatment.

The length of the programme depends on a professional assessment. You are offered a quick appointment with a quality-assured partner, and we settle directly with the therapist.

Reimbursement and subsidies
Treatment by authorised therapists is covered. Massage must be performed by a registered physiotherapist. Shockwave therapy must be performed by an authorised physiotherapist or chiropractor using focused shockwave equipment/ focused machines.

If you have a doctor's referral for physiotherapy and the therapist works within the National Health Service, we will typically use your referral and cover the patient share after reimbursement from the National Health Service. This also applies to treatment in our network.

If you choose a therapist without an agreement, the insurance covers the therapist's fee, up to a maximum amount corresponding to the full fee for general physiotherapy, cf. the indexed rates in the agreement. Group exercise training with a physiotherapist is covered if it is part of a covered course of treatment and is approved by us. Group exercise training is covered corresponding to the full fee for group exercise training, which is indexed annually.

For chiropractic treatment, a maximum amount corresponding to the patient share is covered at the rate that applies to general chiropractic treatment.

For physiotherapy massage, a maximum of DKK 300 per treatment (30 minutes) is covered.

For shock wave therapy, a maximum of DKK 500 per treatment is covered when the treatment is performed as a stand-alone treatment. When the treatment is provided as supplementary treatment, a maximum of DKK 220 is covered in addition to the other rates for normal treatment by a physiotherapist or chiropractor.

You pay the therapist yourself. When your course of treatment is complete, you must submit a copy of all original bills.

Advice and pain education for long-term and chronic musculoskeletal pain
The healthcare team offers guidance and treatment based on the latest evidence on long-term and chronic musculoskeletal pain, including:

- Advising on and assessing treatment needs and methods
- Providing guidance on training and prevention
- Helping to reduce the risk of overtreatment
- Referring to relevant treatment and health services both within and outside the company's network, including GLA:D training programmes for hip, knee and back.

Based on the latest knowledge on long-term and chronic pain, the healthcare team may also refer you to targeted programmes with specially trained practitioners who provide pain education.

The programme provides the participant with practical tools to achieve a better level of functioning – both in daily life and at work. The purpose of the programme is to:

- Increase understanding of your own pain
- Provide tools to manage pain in everyday life
- Strengthen the balance between activity and rest
- Manage fatigue and worries associated with pain.

Psychological counselling for persistent mental disorders
The option covers reasonable and necessary individual psychological counselling and supportive conversations for mental disorders that we assess as persistent, e.g. long-term stress, depression, attention deficit disorders (ADHD/ADD and subtypes), autism spectrum disorders, Tourette's syndrome, persistent anxiety disorders, eating disorders, OCD, phobias, PTSD and complicated grief states/prolonged grief disorder, including grief conditions in children, as well as support for relatives of people with severe mental illness, relatives of people with dementia/Alzheimer's, and support for individuals and relatives of people with dementia/Alzheimer's, ALS, multiple sclerosis, and Parkinson's disease.

The courses are covered regardless of whether the disorder occurred before or during the insurance period.

Other mental disorders and conditions are not covered, including behavioural corrective treatment by a psychologist, e.g. problems with temperament, infidelity, kleptomania, comfort eating, obesity or addiction, couple therapy, family therapy, family sessions, coaching, self-development and the like.

Treatment in our quality-assured network
Following a professional assessment, we can refer you to individual face-to-face or online/digital/telephone treatment with a psychologist or psychotherapist in our network. The insurance covers the necessary number of treatments for up to six months 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.

The therapist can choose to stop a course of treatment if the treatment is deemed to be ineffective.

The age limit for telephone and online treatment is 15 years. The sessions last approximately 30 minutes.

A maximum of one programme per disorder/problem can be covered. If you choose to discontinue a programme early, the programme is considered completed and no further cover will be provided.

Podiatry
This option covers treatment by a podiatrist if you have a referral from your GP due to diabetes, rheumatoid arthritis, psoriatic arthritis, ingrown nails or scar tissue after radiotherapy. Up to six treatments per calendar year are covered, regardless of whether the condition occurred before or during the insurance period. For diabetics, an annual foot check-up is covered.

You can choose which therapist to use. However, you must have a valid doctor's referral for podiatry, and the treatment must be performed in Denmark by a state-authorised podiatrist with an agreement with the National Health Service/regions (provider number).

The amount corresponding to the co-payment (patient share) is covered after subsidisation from the National Health Service at the rates for podiatrists regulated by the collective agreement. The insurance does not cover distance allowance, travelling allowance, inserts, fitting of inserts and the like.

6.6 Optional cover G: online emergency medical service

The cover only applies if it is stated in the insurance contract.

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 – even if the insured's spouse/partner or children living at home are not enrolled in the insurance.

Use of the service requires a Danish civil registration (CPR) number or a valid replacement CPR number, unless otherwise stated in the insurance contract.

The online emergency medical service is a supplement to your general therapist, offering 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 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.

6.7 Optional cover H: extended psychiatric assessment

The cover only applies if it is stated in the insurance contract.

Co-insured persons are only covered by this optional cover if it is stated in the insurance contract/policy – this also applies to children covered under a group insurance scheme.

For co-insured persons, who are covered, extended psychiatric assessment can only be covered once they have been included in the cover for six months. This applies regardless of the seniority provisions in the general terms and conditions – and it also applies to children covered under a group policy.

The optional cover is a supplement to the basic cover of the insurance. The full insurance conditions therefore apply to the optional cover, as do the specific rules and exclusions set out in the optional cover.

Assessment
With this optional cover, reasonable and necessary expenses are covered for initial examinations in connection with outpatient assessment and first-time diagnosis of ADHD/ADD and subtypes and/or ASD (and all underlying types within the autism spectrum). Cover is provided regardless of whether the symptoms occurred before or during the insurance period. The assessment must be carried out during the insurance period.

Expenses are covered for one complete assessment pathway per insured, including combined assessment for ADHD/ADD and ASD where comorbidity is suspected.

Cover is conditional upon the healthcare team assessing that there is documented clinically or medically justified need for assessment and/or a substantiated suspicion of a diagnosis. The assessment is made in accordance with the national clinical guidelines, which ensure high professional standards and consistent quality in assessment and treatment. We may require you to submit a written referral from a doctor.

For children under the age of 15, there must also be a documented educational need, for example from the school, the local educational psychology service, the municipal caseworker or similar. Children can be covered from school age.

For adults, assessment is only relevant if the symptoms cause significant impairment across daily functioning, and if the symptoms have been persistent with onset before the age of 12, in accordance with the national clinical guidelines.

We will refer you to a treatment provider.

The ten-working-day treatment guarantee does not apply to this optional cover.

The content and duration of the assessment process are determined by the treatment provider based on a professional evaluation.

After assessment/diagnosis

If we have covered the assessment and a diagnosis within ADHD/ADD is made, we may – based on a professional evaluation and directly following the diagnosis arranged through the company – cover any initiation of medical treatment and follow-up and adjustment of medication until a stabilised dose is reached, for a maximum of six months from the date of diagnosis.

Therapy and/or group programmes are not covered after a diagnosis has been made.

The insurance does not cover a new assessment and/or a second opinion in cases where a diagnosis has previously been made. In such cases, referral will instead be made to the public psychiatric services.

The limitation of one assessment programme also applies if you resume an insurance relationship or take out a new insurance policy with Dansk Sundhedssikring.

6.8 Optional cover K: surgery for chronic musculoskeletal disorders

The cover only applies if it is stated in the insurance contract.

The optional cover is a supplement to the basic cover of the insurance. The full insurance conditions therefore apply to this optional cover, including section 6.4 “Optional cover E: private hospital cover” and section 7 “What the insurance does not cover” – as well as the specific rules and exclusions set out in this optional cover.

This insurance covers reasonable and necessary initial examinations and surgery for chronic musculoskeletal disorders if we believe it can cure or significantly and permanently improve the condition.

You must always have a valid referral from your GP.

We will refer you to a treatment centre with which we cooperate.

You must always use the therapist designated by us.

Surgery for chronic musculoskeletal disorders is covered, regardless of whether the condition was diagnosed before or during the insurance period. Ongoing and planned treatment is not covered.

However, for co-insured family members with an applicable waiting period, conditions that have arisen and/or been diagnosed before the start of the insurance period will not be covered until after the end of the waiting period. Group child cover does not have a waiting period.

The operation must always be performed during the insurance period.

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

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

One re-operation after a covered surgery for a chronic musculoskeletal disorder is covered if the primary surgery was performed at a treatment centre designated by us. The re-operation must be prescribed by a specialist and approved by Dansk Sundhedssikring's doctor. We will refer you to a treatment centre.

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

The insurance does not cover examination and treatment/surgery for chronic musculoskeletal disorders that we consider complicated and highly specialised and which, in our judgement, are best performed in the public healthcare system.

Rehabilitation after a covered surgery for a chronic musculoskeletal disorder is covered in accordance with the provisions in the section 5.8 "Rehabilitation".

The insurance does not cover examination and treatment/surgery of congenital disorders and disorders that can be related to the birth/foetal stage, as well as the consequences thereof, e.g. hip dysplasia, deformities and scoliosis. Reconstructions, amputations, transplants, replacement of prostheses and the like, as well as assessment and treatment of leg length discrepancy, are not covered.

7. 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, cf. the provisions in section 4.3 "Emergency treatment is not covered". The insurance covers expenses for psychological treatment in the event of acute crisis counselling, cf. the provisions in section 5.8.1 "Emergency crisis counselling".
- Preventive, supportive, maintenance and palliative examination and treatment, unless otherwise stated in the individual cover.
- Vaccinations, health examinations, health checks and other preventive check-ups.
- Chronic/long-term diseases that occurred/became symptomatic and/or were diagnosed before the insurance came into force, unless otherwise stated in the individual cover. 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. Chronic conditions include diabetes type 1 and 2, metabolic disorders, blood disorders, all forms of arthritis and degenerative disorders, including osteoarthritis and age-related back wear, spondylosis, bone diseases, muscular and connective tissue diseases, bunions, sunken forefoot, chronic pain, fibromyalgia, Scheuermann's disease, osteoporosis, chronic bronchitis, cystic fibrosis, migraine, epilepsy, Parkinson's disease, whiplash, multiple sclerosis, ALS, peptic ulcer, reflux, chronic intestinal inflammation, irritable bowel syndrome, glaucoma, tinnitus, Ménière's disease, cholesteatoma, endometriosis and similar.
- Hormonal disorders, including hormonal imbalance, symptoms of hormonal imbalance and similar conditions. The insurance covers specialist-referred examination of hormonal disorders requiring treatment in cases where, in our judgement, your GP is unable to carry out the examination in his/her practice. If your GP has recommended or referred you to a public hospital for assessment, the insurance does not provide cover. Assessment of hormonal disorders that have been previously diagnosed or are previously known, and where a worsening is experienced, is not covered.
- Congenital physical and physical and psychological 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 leg length difference (anisomelia) and dyspraxia.
- Treatment of asthma and allergies.
- Assessment and treatment of anal fissure, anal fistula, pilonidal cysts, anal and mucosal prolapse and haemorrhoids.
- Examination, treatment and surgeries of cosmetic disorders and their consequences, including conditions that are considered cosmetic for the purpose of these conditions, such as breast augmentation and reduction surgeries for whatever reason, breast reconstruction, examination and replacement/removal of implants for any reason, brow lifts and gynaecomastia.

- Assessment and treatment of drooping eyelids (lower and upper).
- Treatment with Botox or Xiapex and similar treatments, MiraDry and other treatments for sweating/hyperhidrosis and any comparable treatments.
- Treatment or surgery for overweight/obesity and its consequences, including gastric bypass, gastric sleeve and the like, excess skin surgery after weight loss. Psychological treatment for obesity. Dietician treatment for obesity is covered based on the special provisions for the optional cover "Optional cover A: acupuncture, reflexology, osteopathy and dietician".
- Skin conditions that we do not consider to have a significant impact on health and/or that we consider to be cosmetic or chronic, such as benign moles and spots, lipomas, pigmentation changes, acne, eczema and eczema-like skin conditions, rashes and eczema/rash caused by allergies, hair loss, all types of warts, nail fungus, corns, psoriasis, vitiligo, rosacea, skin transplants, sun damage to the skin, actinic and seborrhoeic keratosis and similar skin conditions. Treatment of recurrent skin conditions, treatment with Mohs surgery or similar types of treatment.
- Assessment and treatment of venereal diseases, HIV/AIDS and its precursors and sequelae. Contraception, including sterilisation, insertion and removal of IUDs for whatever reason and their consequences and assessment and treatment of altered sexual function.
- Assessment and treatment of infertility and fertility and its consequences. This also applies to psychological consequences.
- Abortion. The insurance covers GP-referred psychological treatment of postpartum reactions, postpartum depression and post-abortion discomfort requiring treatment.
- Examinations, check-ups, scan, birth preparation, private midwife and similar in connection with pregnancy and childbirth (here we refer you to the public services, and we provide counselling in the further process).
- Diseases of the unborn child. Colic pain and colic-like conditions in children, as well as growing pains and child incontinence.
- Treatment and assessment of ADHD, ADD and subtypes, ASD and all subtypes of autism spectrum disorders), unless separate cover for this has been taken out, and Tourettes syndrom, dementia and eating disorders, including any resulting complications or consequences. Assessment and treatment of gender dysphoria or resulting consequences.
- Treatment of severe mental illness, e.g. bipolar disorder, personality disorders, schizophrenia, psychoses, PTSD and diagnosed complicated grief unless otherwise stated in the individual cover. Treatment of diagnosed mental illnesses that fall under the public treatment packages.
- Consultations with a neuropsychologist.
- Talk therapy and medication by a psychiatrist.
- Expenses for medication other than those specified in section 5.6.4 "Medication expenses".

- Behavioural treatment by a psychologist, e.g. temperamental problems, infidelity, kleptomania, comfort eating and addiction (e.g. sex addition, porn addition and gambling addition).

- Couples therapy, parental and family counselling, family therapy, group therapy, coaching, self-development, personal development and similar, supportive and maintenance counselling and psychological treatments of a preventive and maintenance nature.

- Treatment of phobias, such as fear of flying, fear of heights, dental anxiety, exam anxiety and social phobia and similar conditions. Treatment of OCD, OCD anxiety and its sequelae. Recurrent anxiety, that also applies recurring 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.

- Assessment and/or treatment pathways for mental disorders that we consider to be of high complexity, and which we assess are best carried out within the public healthcare system. This may, for example, include pathways involving complex clinical presentations with multiple concurrent mental disorders and/or pathways requiring multidisciplinary treatment services or specialised expertise.

- Diseases or conditions that are included in a standardised treatment package within the public healthcare system.

- If you have been referred to a public psychiatric package programme.

- Heart rhythm disorders, including radiofrequency ablation (RFA), DC conversion, high blood pressure, hereditary high cholesterol, atherosclerosis, high cholesterol and coronary artery stenosis, CAD, vascular surgery and heart surgery. The insurance covers assessment and examination of any symptoms of heart problems in cases where your GP has referred you to cardiological examination and treatment (e.g. echocardiography, ECG, pulmonary function tests and 24-hour monitoring of heart rate and blood pressure).

- Treatment of sleep problems, snoring problems, sleep disorders, including sleep apnoea and snoring treatment. Treatment at a sleep clinic and the like. Sleep assessment is covered based on the applicable provisions in section 5.6 'Sleep assessment'.

- Dental treatment, dental surgery, jaw surgery, chewing injuries, dental prostheses, bridges, bone reconstruction, occlusal splints and discomfort/injuries to teeth, oral cavity and jaws. Dental injury in direct connection with a covered claim where the treatment was initiated by us is covered based on the provisions in section 5.10 "Dental treatment".

- Sequelae of abuse of medication, alcohol, narcotics or other intoxicants.

- Assessment, examination and treatment of all types of visual impairment and visual field symptoms, nearsightedness, farsightedness, astigmatism, binocular vision, co-vision problems, co-vision training, vision correction, dry eyes, floaters and eye spots, vitreous haze, strabismus, binocular vision problems and AMD. Cataracts are covered based on the provisions in section 5.6 "Cataracts".

- Vitrectomy, vitreolysis. Vision corrective lens, regardless of cause and regardless of lens type. Lens replacement.

- Glasses, contact lenses and/or vision testing, eye examination or other vision corrective treatments and aids.

- Hearing correction examinations, treatments and surgeries, including general hearing examinations, hearing tests, other hearing-enhancing treatments, and hearing aids.

- Treatments outside normal working hours, including weekend and evening supplements and the like as well as additional services in connection with treatment such as shockwave, laser treatment, ultrasound, acupuncture, massage, ultrasound scan and the like, unless otherwise stated in the individual cover. Ultrasound scans are covered in relevant cases in accordance with the provisions of section 5.6 “Examination and treatment by a medical specialist”.

- Pool training.

- Additional expenses for soles, inserts, bandages, tape, etc.

- Diet plan in connection with treatment with a dietician.

- 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, laughing gas, solvents, medication or other intoxicants. Self-inflicted injury caused by intent or gross negligence, e.g. fights, suicide attempts, participation in criminal offences. Injuries caused by your failure to follow medical recommendations.

- Illness/injury, discomforts, infections and other consequences of implants, tattoos, piercings, prostheses, oil injections, anabolic steroids, doping 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.

- Examination/treatment that is experimental and not medically justified or has proven efficacy.

- Growth factor and orthokine therapy, cryoneurolysis, PRF therapy, PRP therapy, HVI, hyaluronic acid (injections), Modic changes and other treatment that comparable to the above.

- Assessment and treatment of long-term and/or chronic pain problems at specialised clinics and pain treatment in connection with cancer. The healthcare team helps with counselling in the further process.

- Assessment and treatment at specialised clinics, such as Modic, headache, pain, sleep, cough or memory clinics and similar specialised clinics.

- Physiotherapy and chiropractic care for asthma and allergy disorders, insomnia, hypertension, cardiovascular disorders, Parkinson's disease, epilepsy, memory disorders, diagnosed headache disorders and jaw tension and jaw problems. The insurance covers professionally justified treatment of tension headaches caused by neck, shoulder and back tension.

- Physiotherapy for illness/injury/diagnosis where the treatment is covered under the free physiotherapy scheme.

- Complicated thyroid and parathyroid surgery, replacement of prostheses and the like.

- Private expenses, including hotel and companion expenses, private expenses during hospitalisation or similar and expenses for interpreter assistance.

- Assessment and treatment pathways, as well as diseases, injuries and conditions that we consider to be of high complexity and/or highly specialised, and which we assess are best carried out within the public healthcare system. This also applies to rare and complicated clinical pathways that require the involvement of multiple interdisciplinary functions/specialists or multidisciplinary teams or that require particular surgical expertise. This may, for example, include clinical presentations with concurrent or suspected multiple conditions, or assessment and treatment which, according to the Danish Health Authority's specialist plan (or guidelines), must be undertaken by a highly specialised function. This includes, among other things, complex reconstructions, amputations, transplants, organ donation and organ transplantation, dialysis treatment, gender reassignment surgery, proton therapy and treatment with stem cells.

- Injuries/diseases 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 and the like.

- Cases of force majeure that result in limited capacity, including illness/injury and need for treatment arising, for example, from societal actions, general strikes, natural disasters, infrastructure problems, IT outages, hacker attacks, lack of electricity supply or network connections, epidemics, pandemics and virus infections and vaccines related thereto. Complications and treatment needs arising from epidemics, pandemics and vaccines.

8. General provisions

Communication

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

Communication with you in connection with your reported claims takes place either by phone or via the claims function on the insurance company's user portal.

8.1 Duration of the insurance

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

8.2 Sum insured

The insurance covers reasonable and necessary customary expenses for illnesses, injuries and ailments based on the provisions of the individual covers.

8.3 Payment of the insurance

The insurance is paid for the first time when it comes into effect. Subsequent payments follow the contract. We will send an invoice to the 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. 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.

8.4 Premium adjustment and changes to insurance conditions

The price is adjusted once a year, unless otherwise agreed. An annual statement is prepared of the actual number of insureds versus the number paid for. Any difference is credited or debited to the policyholder.

The premium is set once a year on the annual renewal date. Premium adjustments are based on the previous year's claims account as well as the wage index for the private sector published by Statistics Denmark, unless otherwise stated in the contract. If this index ceases to exist or if the basis for its calculation changes, we are entitled to use a similar index from Statistics Denmark.

Premium adjustments may occur in addition to indexation and statutory changes. If the premium is adjusted, you can choose to cancel the contract in writing with one month's notice after you received the notification of the renewal premium. If the price is based on assumptions that no longer exist, we may adjust the price at the next annual renewal date. If risk accounts are prepared for the insurance, the price will be adjusted according to special rules.

In addition to the index adjustment, we can change the conditions and/or price for already established schemes with one month's notice to the end of a month. The price will be adjusted by a percentage set by Dansk Sundhedssikring.

If you cannot accept the changes, you must cancel 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 cancelled in writing, the insurance will continue with the changed insurance conditions and/or price.

We regularly assess whether there is a need to amend the insurance conditions. Such amendments may be due to various factors, e.g. changes in legislation, tax and duty regulations, market conditions, product changes, and financial circumstances such as increasing supplier costs (beyond index) or rising claims expenses.

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

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

8.5 Termination and cessation of the insurance

Insurance policies taken out for one year at a time are automatically renewed from the annual renewal date. Unless otherwise agreed, an annual policy is taken out with an annual statement of debit or credit.

The insurance can be cancelled in writing by the policyholder or Dansk Sundhedssikring with one month's notice to the expiry of the period. If the insurance is not cancelled, it will be renewed for one year at a time.

In the event of signs of fraud or attempted fraud, we can cancel the insurance without notice.

The insurance ceases at the end of the month in which your employment ends, if you leave the scheme, if you pass away, or in the event of non-payment of the premium.

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

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

In the event of non-payment of the insurance premium, the rules under section 8.3 "Payment of the insurance" will be followed.

Cover on termination of the insurance

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

Co-insured

For co-insured family members of a principal insured who are covered under a company scheme, the insurance will continue to the date for which cover has been paid, in cases where the principal insured leaves the scheme.

Co-insured children who turn 24 during the payment period are covered until the next payment period. For group child cover, cover for children always ceases if the principal insured's cover ends or at the end of the month in which the child reaches the age of 24, unless a different age applies to the contract.

Continuation of the insurance

If you are no longer covered by the company scheme, you can under our rules apply to continue your insurance on our individual conditions and at our individual price for private individuals. Your request for continuation must be made before or in direct connection with the withdrawal from the previous insurance contract. The insurance will then be continued without a waiting period for existing disorders. If you do not request continuation without delay, there will be a six-month waiting period for existing conditions. Co-insured persons also have the option of applying for continuation of the insurance on our individual conditions and at our individual price for private individuals.

Reimbursement of bills after termination of the insurance

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

8.6 Duty of disclosure

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

We have the right to ask about your health, and you are obliged to provide us with all relevant information, including permission for us to obtain necessary information from doctors, hospitals and other professionals who have relevant knowledge of your health. We may obtain the information we deem necessary, including obtaining medical records or other written material about your health. We will only ever collect information with your consent.

The information relates to both the period before and after the insurance takes effect.

Membership of Sygeforsikringen "danmark" must always be stated in connection with the filing of a claim, as we are entitled to this subsidy.

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

When you resign from your position

When reporting a disease/injury or if you request treatment, you are obliged to inform us if you have resigned or leave the company. The insurance covers authorised claims reported during the insurance period for up to three months from the date you leave the company. We can claim reimbursement of expenses for examination or treatment if you have failed to inform us that you have left the company and have received more than three months of treatment.

Double insurance

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

8.7 Processing of personal data

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

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

On our website you can read more about data security and how we process your personal data. In certain cases, we may disclose your personal data to suppliers with whom we co-operate.

8.8 Processing of health information

There is no requirement to provide health information when you take out insurance with us. However, if you wish to join the scheme after having previously provided a waiver, we may require you to provide necessary health information. By reporting a disease/injury, you accept that we may obtain information about health conditions if we deem it relevant in connection with the reported disease/injury. We can obtain this information from the healthcare system and public authorities, including municipalities, Labour Market Insurance, insurance companies, pension companies and sundhed.dk. The information is always obtained with your written or verbal consent.

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

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

8.9 Incorrect information

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

8.10 Time limitation

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

8.11 Avenues of complaint

If you disagree with or are dissatisfied with our decision, you should contact the department that handled the case. If you are still not satisfied after contacting the department, you can write to our complaints officer to have your case reassessed. Your complaint will be handled by a complaints officer as soon as possible and within seven work-ing days at the latest. You can submit your complaint via the complaints portal on our website.

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

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

Governing law

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

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

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

8.12 If you want to know more

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

You can find more information on our website where you also can find our phone number and report your claim online.