Critical illness and accident insurance

September 2024

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Group and accident insurance applying to P+ Life cycle

The group insurance covers in the event of certain critical illnesses.

The accident insurance covers accidents. The insurances run for one year at a time and can be changed annually on 1 January.

The group insurance in the event of certain critical illnesses, **agreement no. 98707**, is entered into with:

Forenede Gruppeliv ('FG')
Krumtappen 4, 1
2500 Valby
Phone no. 3916 7800
fg@fg.dk
www.fg.dk

FG is the insurance provider on behalf of the companies owning FG. Information about FG's owner companies and their liability appear from FG's website

Hence, a member of P+ is covered by a group life insurance that is taken out by P+ (as the policyholder) through FG (as the insurance provider) with FG's four owners (as insurance companies).

FG provides P+'s members with advisory services in relation to the group insurance in the event of death, disability and certain critical illnesses.

The accident insurance, **policy no. 646-753-545-3**, is taken out with:

Codan Forsikring A/S
Skade Ulykke
Midtermolen 7
2100 København Ø
www.codan.dk

Codan is owned by Alm. Brand Forsikring, CVR no. 10526949.

Codan provides advisory services in relation to the accident insurance.

Who is covered?
Paying members and members who are subject to non-contributory cover.

Termination of cover
The insurance in the event of certain critical illnesses as well as the accident insurance are terminated when you start receiving retirement pension benefits in P+, however no later than at the end of the month in which you reach age 68.

The insurances are terminated if you are transferred to dormant membership before age 68, or you terminate your membership of P+.

Accident insurance
The paid compensation depends on the degree of injury and the maximum lump sum compensation, as the lump sum compensation it is paid as a percentage of the maximum sum accounting for DKK 850.000. Hence, in case of a 50 percent degree of permanent injury, the lump sum compensation will account for DKK 425.000.

Dental injury is covered according to vouchers submitted.

Certain critical illnesses
If you contract one of the critical illnesses specified in enclosure 2 *Insurance terms - critical illnesses* before reaching age 68, an insurance sum is paid.

Insurance sum - certain critical illnesses

Under 60	DKK	150.000
60 - 68	DKK	133.000
Reached age 68	DKK	0

Cover of certain critical illnesses is based on the condition that the illness is diagnosed in the policy period. Diagnoses established after expiry of the policy period are not covered by the insurance. Payment from the critical illness insurance is tax-free.

Making use of the insurance

Accident
If you have an accident, you must contact Codan that handles the case and pays the accident sum if the conditions for payment are met. You can download a claim form on pplus.dk

Certain critial illnesses
If you contract one the certain critical illnesses stated in the insurance terms, you must contact P+.

The premium
P+ pays the group insurance premium. The premium is taxable, and payment is tax-free. P+ reports the premium to SKAT as personal income.

Availability and disputes
Your insurances cannot be sold, pawned or in other way be made object of sale or prosecution.

You can bring disputes regarding the insurances before the courts or the Insurance Complaints Board. The complaint must, along with a small fee, be send on a special complaint form which you can acquire at the Insurance Complaints Board, Forenede Gruppeliv or Codan Forsikring.

If you have questions?
You are always welcome to contact us on kontakt@pplus.dk or 3818 8700 if you have questions.

Insurance terms - accident insurance
See enclosure 1.

Insurance terms - certain critical illnesses
See enclosure 2.

Enclosure 1 – accident insurance

Common insurance terms

1. Scope and group of people
The member is subject to the insurance on residence or employment in Denmark. Expats are subject to the insurance if the conditions of section 6 are met.

The total compensation for the same incident can as a maximum account for DKK 1.5 billion.

2. What does the insurance cover?
The insurance covers accidents when the degree of disability exceeds 5 percent.

An accident is defined as a sudden incident causing personal injury.

The accident must occur in the policy period, cf. section 4.

In order to be covered there must be a causality between the accident and the injury. In the assessment it is emphasised whether the incident is suitable for causing personal injury - e.g. whether the incident in itself is sufficient to cause/explain the injury.

The insurance covers even though the accident occurs while the injured was flying a private plane or riding a motorcycle.

3. What does the insurance not cover?
Regardless of the injured's state of mind at the time of the injury, the insurance does not cover:

- Injuries caused by the injured with intent or by grave negligence.
- Injuries caused by overburdening.
- Injuries caused by the injured during self-inflicted intoxication or under the influence of narcotics or the like.
- Injuries caused by poising due to medicine.
- Injuries caused by infection with virus, germs and other microorganisms.
- Injuries caused by involvement in fights.
- Injuries caused by involvement in illegal actions.
- Injuries caused by participation in boxing, any kind of races, mountaineering, parachute jumping and hang-gliding or comparable sports.
- Injuries caused by nuclear energy in any case, including war.
- Injuries caused by conflicts in the form of war, riots or civil violence unless the injury occurs within one month after the outbreak of the conflict in a country where the insured stays during travelling. Moreover, it is a condition that the conflict did not exist at the entry into the country, and that the insured does not participate in the actions.

4. Policy period
The insurance covers consequences of accidents when the accident occurs during the policy period.

The policy period is the period between the insurance's commencement and termination date for the insured.

The insurance does not cover consequences, including worsening of consequences, showing more than 5 years after the accident occurred or the illness was diagnosed.

5. Where does the insurance cover?
The insurance covers worldwide, unless otherwise agreed or according to the conditions of sections 3 and 6.

6. Expatriation
Members, who as part of their employment are expatriated outside Denmark, are covered by the accident insurance if:

- the expatriation takes place from Denmark
- Codan is informed about the name of the expatriate and the country of expatriation.

The member is covered by the accident insurance when Codan has approved the country of expatriation. It is the member's responsibility to get the approval from Codan.

Determination of a permanent injury and payment of compensation are based on a specialist examination carried out in Denmark. Any expenses involved are paid by Codan.

A possible compensation is paid to the Danish bank account of the member or the member's next of kin.

The insurance does not cover expenses related to treatment, including dental treatment, carried out outside Denmark.

7. In case of an injury
The injured must be under constant treatment by a doctor and comply with the orders given. Codan's liability to pay compensation is conditional on the injured seeing a doctor immediately.

Codan is entitled to obtain information with any doctor, medical institution or others treating or having treated the injured and have the person in question examined by a doctor chosen by Codan.

Codan may require that the injured is examined by a doctor in Denmark who Codan approves and pays for. If the injured does not agree to being examined by a doctor approved by Codan, Codan may decline any claim for compensation.

Regardless of whether the inured resides in Denmark or abroad, Codan does not cover transportation charges or expenses related to the stay in Denmark. Codan only pays for the medical certificates which the company requires.

If the insurance includes cover of dental injury, treatment and price must be approved by Codan before treatment is started unless it is an urgent treatment. Codan may require that treatment is carried out in Denmark.

8. Submission of claim form
Injuries covered by the insurance must be filed in writing to Codan as soon as possible.

Injuries can be filed with Codan on phone no. 3355 3830 or www.codan.dk

If an injury causes death, Codan must be informed about this within 48 hours. Codan is entitled to require an autopsy.

9. Limitation in respect of a claim
Cover of injuries is subject to the standard provisions stipulated in the Insurance Contracts Act, cf. the conditions of section 4, paragraph 3, however.

10. Calculation of compensation
The compensation is calculated on basis of the size of the insurance sum at the time of the injury and according to the rules appearing from the individual covers.

11. Payment of compensation
Codan's standard method of payment is a bank transfer. On payment related to an injury, Codan must have information about bank and account number.

The compensation may also be paid by cheque against a fee which is deducted from the compensation amount.

12. Other insurances
The insurance benefits are paid regardless of other potential insurance benefits which are paid as a result of the injury unless otherwise stipulated in the insurance terms for the individual covers.

13. Who has the right to dispose of the insurance?
The right to dispose of the insurance in full rests with the policyholder.

14. Labour Market Insurance
On request from one of the parties, Labour Market Insurance can give an indicative opinion about the level of disability, and whether there is a causal relation between the filed suffering and injury.

Labour Market Insurance's fee is split between the parties, however Codan pays the entire fee if Labour Market Insurance determines a higher level of disability compared to the one that Codan has determined.

15. Insurance disputes
If the insured does not agree to Codans decision of a matter, the insured can contact the department that has processed it.

If the insured is still not content, it is possible to contact Codan's complaints officer on klageansvarlig@codan.dk

If the parties still cannot come to an agreement, the insured can address:

The Insurance Complaints Board
Østergade 18, 2. floor
1100 Copenhagen K
Phone no. 3315 8900 (from 10am – 1pm)
www.ankeforsikring.dk

Complaints to the Insurance Complaints Board must be made by completing a special complaints form, and a fee is payable. The complaints form and payment information is available here

The agreement is governed by Danish law, including the existing Danish Insurance Contracts Act. If a dispute about the insurance agreement is brought before the court, it is settled pursuant to Danish law in the Danish courts and pursuant to the Administration of Justice Act's rules on jurisdiction.

16. Sanctions
Codan Forsikring A/S and their subsidiaries/branch offices do not cover and are not obliged to pay any kind of compensation or other benefits according to the insurance to the extent that such an insurance cover, payment of such a claim or providing such an insurance benefit will expose Codan Forsikring A/S and/or their subsidiaries/branch offices to any sanction, prohibition or restriction approved by the UN, the EU, Great Britain or the US.

Enclosure 1.A – accident insurance

Disability cover in the event of an accident

1. Scope of the disability cover
When an accident, see the common insurance terms' section 2, is the direct cause of the insured party's medical disability (= injury) being determined to at least 5 percent, a compensation is paid.

The degree of disability is determined in accordance with the disability table used by the Danish Labour Market Insurance at the decision time, with the limitations mentioned below and in section 3.

If the degree of disability cannot be directly determined according to the Danish Labour Market Insurance's disability table, the degree of the insured person's medical disability is determined according to the principles underlying the disability table, based on the physical functional impairment.

In every case, the degree of disability is determined purely on a medical basis, without considering any potential reduction in working capacity, the injured party's specific occupation, or other individual circumstances.

The compensation accounts for the percentage of the insurance sum that corresponds to the determined degree of disability.

Any pre-existing disability cannot result in the compensation being set higher than it would have been if such disability had not been present. In the case of injury to paired organs, this means that the degree of disability, regardless of any pre-existing disability, is determined as if there is only a disability in the most recently injured organ.

The degree of disability cannot exceed 100 percent for the same accident.

The compensation is determined as soon as it is considered certain that the accident and the resulting sufferings will not result in death, and the injured party's condition is otherwise considered stable.

2. Who receives the compensation?
The compensatoiin is paid to the injured party.

If the injured party is a child, and the compensation exceeds DKK 100,000, 10 percent of the compensation is paid to the holder of parental authority.

The part of the compensation that is paid to the child is managed according to the regulations related to funds for minors.

3. What does the disability cover not include?
- Disability caused by injuries mentioned in section 3 of the common insurance terms.
- Disabililty when the accident is caused by illness.
- Disability caused by any illness, pre-existing illness, predisposition or suffering, regardless of the illness, the predisposing illness or suffering being symptomatic or not before the accident.
- Disability caused by an existing or incidental illness impairing the consequences of an accident.
- Disabililty that existed prior to the accident, cf. section 1.
- Disability that alone is an impairment of a pre-existing suffering.
- Disability caused by a consequence of heatstroke, sunstroke etc.
- Disability caused by overstrain of other body parts than those injured in the accident.
- Disability in the form of mental issues resulting from incidents where the injured party has not been directy exposed to the risk of physical injury.
- Disability resulting from dental/medical treatment or similar treatment, if the treatment is not necessitated by a covered accident.

4. Expenses related to treatment/rehabilitation
The insured party is entitled to cover of below expenses related to treatment/rehabilitation after an accident which is covered by the insurance if upon consultation with their GP the need for treatment is established, and the insured party is referred to or recommended for treatment.

Cover is dependent on that the expensesa, according to a medical assessment, have a healing effect. The insurance does not cover treatment that only has a short-term/alleviating effect.

Expenses related to treatment of overburdening of other body parts than those injured in the accident are not covered by the insurance.

There may limitations related to time or number of treatments for each cover.

Expenses related to treatment/rehabilitation may be covered until the degree of injury has been established, and the total maximum compensation for all covers amounts to 2 percent of the disability sum at the time of the injury.

The expenses are only covered if the injured party is not entitled to having them covered elsewhere, e.g. via an industrial injury insurance, the public health insurance, Sygeforsikringen danmark etc.

Physiotherapy/chiropractic
The insurance covers expenses relatd to treatment at a chiropractor or physiotherapist. The insurance covers an amount corresponding to the patient's share for treatments that are eligible for public subsidies.

Acupuncture
Acupuncture is covered with up to 10 treatments. The practitioner must be a doctor, a member of the Association of Practicing Acupuncturists (Foreningen af praktiserende akupunktører) or a registered alternative practitioner.

Reflexology
Reflexology is covered with up to 10 treatments. The reflexologist must be a registered alternative practitioner.

Craniosacral therapy
Craniosacral therapy is covered with up to 5 treatments. The practitioner must be a registered alternative practitioner.

Psychologist/crisis counselling
The insurance covers, cf. section 3, the second last paragraph, not disability in the form of mental issues or incidents where the injured party has not been exposed to direct danger of physical personal injury.

The insurace covers, however, crisis counselling expenses at a licensed psychologist related to the following traumatic incidents:

- The insured party is exposed to an accident, natural disaster, terrorism, war (see however the common terms section 3, the last paragraph), robbery, assault, kidnapping.
- The insured party wittnesses a colleague's or family member's sudden, unexpected death or serious inury.

The insurance covers up to 10 consultations which must begin no later than 4 weeks after th insurance event and be determined no later than 3 months after the first treatment.

Codan must (as far as possible) be contacted prior to the beginning of the treatment for the purpose of assessing the need for treatment and assisting with arranging it.

Other rehabilitation
Repayment of extraordinary expenses related to courses in a fitness center recommended by a doctor, chiropractor or physiotherapist for up to 3 months.

Furthermore, the insurance covers expenses related to pool exercise in hot water (individually or group) recommended by a doctor, chiropractor or physio-therapist for up to 3 months.

5. Other expenses that may be covered
If an accident covered by the insurance results in a disability degree of at least 5 percent, the insurance covers reasonable and necessary expenses of up to DKK 35,000 (2013) of each of the following covers:

Modification of home
If the accident necessitates the need for physical modifications of the insured party's private home.

The modifications must be commensurate with the incurred disability.

Modification of workplace
If the accident necessitates the need for pysical modifications at the insured party's worksplace.

The modifications must be necessary for the insured party to be able to perform their normal work and must be commensurate with the incurred disability.

It applies to all above-mentioned expenses that they are only covered if the injured party is not entitled to having the costes covered elsewhere – e.g via an industrial injury insurance, the public health insurance, Sygeforsikringen danmark etc.

Expenses not covered
The insurance does not cover any expenses other than those mentioned in section 4 and 5. E.g the following expenses are not covered: transportation charges, legal assistance, medical treatment, treatment at a private hospital or other treatment. Also, expenses related to medication or any kind of assistive technology, e.g. neck braces and support bandages, are not covered by the insurance.

Enclosure 1.B – accident insurance

Cover in the event of dental injury

1. What does the cover include?
When an accident, see the common insurance terms section 2, is the direct cause of a dental injury, the expenses necessary for dental treatment to obtain the same dental status as before the accident are covered.

The dental injury cover also includes removable dentures that are damaged while in the mouth, provided that the accident has also caused other bodily injury.

Dental injuries caused by eating are only covered if the injury is due to a proven foreign object in the food. Codan may require the objective to be sent in.

In the case of pathological or abnormal dental changes, payment will only be made for the part of the injury that would have been the result of the accident had these changes not been present.

The compensation may be reduced or no longer apply if the condition of the teeth or the denture was impaired before the accident. The impairments may include fillings, caries, reconstructions, root canal treatment, wear, paradentosis, attachment loss or other diseases affecting the teeth and the surrounding bones. In the assessment the extent of the impairment in relation to well-preserved teeth or dentures is considered.

If a dental injury requires a dental bridge, and it turns out that adjacent teeth to the damaged tooth are missing or or impaired, the insurance does not cover the extra expenses that this may involve.

If the damaged tooth is part of an existing dental bridge, the insurance only covers repair or replacement of the part of the bridge that is damaged in the accident. When Codan has paid the expenses related to dental treatment, this treatment is considered final, and a compensation for a potential later replacement is not covered.

2. What does the cover not include?

- Injuries mentioned in section 3 of the common insurance terms.
- Dental treatment when the accident is caused by illness.
- Dental treatment caused by any illness, pre-existing illness, predisposition or suffering, regardless of the illness, the predisposition or suffering being symptomatic or not before the accident.
- Dental treatment causing that an existing or coincidental occurrence of an illness worsen the consequences of an accident.
- Dental treatment caused by heatstroke, sunstroke, etc.
- Dental treatment caused by dental or medical treatment or the like if the treatment itself is not necessitated by a result of an accident covered by the insurance.
- Dental treatment paid the insured party, their family, parents or children or a company belonging to the mentioned individuals.

3. Other options for cover
Compensation is only paid if the injured party is not entitled to reimbursement of the expenses elsewhere, e.g. via the public health insurance, Sygeforsikringen danmark, an industrial injury insurance etc.

Enclosure 2 – critical illness

Insurance terms
This is an extract of the Danish insurance terms. The full insurance terms are available on www.fg.dk. In case of inconsistency between below insurance terms and FG's insurance terms, it is the insuance terms on www.fg.dk that apply.

§ 1. Below-mentioned terms are applying to FG's group life agreements and insurance terms.

The insurance covers the illnesses, planned or performed surgeries and consequences of an illness mentioned in § 7 A-Y. Illnesses, surgeries and consequences of an illness are hereafter referred to as diagnoses.

When a diagnosis is made, as required according to the insurance terms, the insurance sum can be paid.

The insurance terms applied and the insurance sum paid corresponds with the insurance terms and insurance sum valid at the time the diagnosis was made.

§ 2. It is a condition for payment in the event of critical illness that the diagnosis is made in the policy period. The diagnosis date is decisive and the time when the insured party becomes aware of the diagnosis. The policy period appears from the group life agreement.

The insurance cover does not include diagnoses in § 7 that the insured party has been diagnosed with or received treatment for prior to the policy period. Diagnoses covered according to each of the provisions § 7 A-Y are considered as one diagnosis. For cancer, 'extended cover for § 7 A' applies.

§ 3. It is stipulated in the group life agreement if cover in the event of critical illness is terminated after payment of an insurance sum in the event of critical illness, see below under a), or if critical illness is still covered, see below under b):

a) When payment has been made according to § 7, the group member's right to further payment in the event of critical illness is terminated.

b) When payment has been made according to § 7, the insurance no longer covers that or those diagnoses which have resulted in payment of an insurance sum in the event of critical illness. Payment can only be made once for each of the provisions § 7 A-Y. For cancer, 'extended cover for § 7 A' applies.

It is a condition for payment of more than one cover that at least 6 months have passed since the last diagnosis eligible for cover was made and the time of the new diagnosis. If payment has been made by acceptance on a waiting list, the 6 months time limit applies from the time of the perfomed surgery.

§ 4. If the insured party dies within the settlement period established in the group life agreement, the paid sum in the event of critical illness is set off against the lump sum death benefit.
§ 5. The right to a payment of the insurance sum in the event of a critical illness is terminated if the insured party dies, unless a written application for payment has been submitted ot FG.

§ 6. If the insured party has withdrawn from the group life agreement, or the group life agreement has terminated due to cancellation or other reasons, a written request for payment must be submitted to FG within 6 months after expiry of the policy period. On expiry of this time limit, the right to payment of the insurance sum in the event of critical illness, which has not been reported, lapses.

§ 7. Critical illness includes:

A. Cancer

1) Cancer with the exception of less aggressive forms

The cover **does not** include:

- Precancerous lesions (dysplasia and 'in situ cancer') e.g. in cervix, breasts or testicles.
- Borderline changes.
- Skin cancer, except from melanoma.
- Kaposi's sarcoma.
- Benign bladder papillomas.
- Grade 1 neuroendoctrine carcionid tumors without sign of invasive growth or metastasis.

The diagnosis of cancer is considered made when a specialist in tissue examination has made the diagnosis on basis of a tissue biopsy or by way of a cytology test.

2) Leukemia, lymphoma and myeloma

The cover includes:

- Acute leukemia.
- Chronic myeloid leukemia.
- Myelomatose.
- Non-Hodgkin's lymphoma.
- Hodgkin's lymphoma in stages II-IV.
- Higher-risk myelodysplastic syndrome (MDS).
- Chronic myelomonocytic leukemia (CMML).

The diagnosis of cancer is considered made when a specialist in diagnostic tissue examination has made one of the above diagnoses based on microscopic and/or flow cytometric examination of blood, bone marrow or other tissue.

Also, below conditions requiring treatment are included:

- Chronic lymphocytic leukemia (CLL) /small lymphocytic lymphoma (SLL)
- Essential thrombocytosis
- Polycythemia vera
- Myelofibrosis

Illnesses requiring treatment implies that the illness requires cytotoxic treatment (including chemotherapy, radiotherapy and biological treatment) aimed at the illness. Treatment with acetylsalic acid, adrenal cortex

hormone and bloodletting is not considered cytoxic treatment.

For cancer types where it is required that the illness requires treatment, the diagnosis is considered made at the time it is entered into the medical record from an oncology or hematology ward that there is an indication for treatment of the illness.

The cover **does not** include:

- Initial stages of cancer in blood, lymph or the hematopoietic organs.
- Lymphoma confined to the skin.

Extended cover for § 7 A
If the insured has been diagnosed with cancer prior to the start of the policy period and at least 10 years have passed without the insured party being diagnosed with cancer, there is a right to payment if the insured party once again during the policy period is diagnosed with a type of cancer with meets the provisions in § 7 A.

There may be made payments for up to two cancer diagnoses made during the policy period and meeting the provisions in § 7 A. However, the second payment is conditional on at least 10 years having passed since the first cancer diagnosis was made during the policy period. It is also a condition for the second payment that no recurrence of the cancer diagnosis or diagnosis of a different type of cancer have been made during the 10-year period.

B. Blood clot in the heart
The diagnosis must be documented and based on:

- Typical rise and fall of the blood levels (troponin or CK-MB).

Along with at least one of the following criteria:

- A medical history of suddenly occurring, typical persistent, chest pain
- Simultaneously occurring electrocardiographic changes consistent with the diagnosis of acute myocardial infarction

The diagnosis is considered made when above-mentioned provisions are met and a cardiology specialist has made the diagnosis blood clot in the heart.

C. Bypass surgery or angioplasty for coronary artery disease
Bypass surgery entitles to payment if the insured party has been accepted to a waiting list.

In case of an angioplasty the surgery must be completed.

The diagnosis is considered made at the day of surgery. For planned bypass surgery it is the date of acceptance on the waiting list.

D. Heart valve surgery
Planned or performed insertion of an artificial mechanical or biological heart valve prosthesis as well as heart valve repair.

In case of planned surgery the insured party must be accepted on a waiting list.

The diagnosis is considered made at the date of surgery. In case of planned surgery it is the date for the acceptance on a waiting list.

E. Brain haemorrhage or stroke
An acute injury of the brain or brainstem.

The diagnosis is considered made at the date of admission to the neurological ward or the date or the date of the first consultation with a neurologist in connection with the stroke.

F. Saccular enlargement of the brain's arteries (aneurysm) or intracranial arteriovenous malformation as well as cavernous angioma in the brain
Planned or performed surgery for a saccular aneurysm of the brain's artieries, intracranial arteriovenous malformation or cavernous angioma which must be proven by x-ray of the brain's arteries or a CT scan/MRI.

The cover also includes cases where there is an indication for surgery, but surgery cannot be performed due to technical reasons.

The diagnosis is consideres made at the date for surgery. In case of a planned surgery it is the date for acceptance on a waiting list. If surgery is not technically possible, it is the date when is is evident from the medical record from a neurological og neurosurgical ward that an indication of surgery exists, but surgery is not technically possible.

G. Certain benign tumors in the brain and spinal cord
Benign tumors located in brain, brainstem, spinal cord or the membrane of these organs (central nervous system) which either:

- cannot be completely removed (radically) by surgery
- after radical surgery leave sequelae of the nervous system which results in a degree of disability of at least 15 percent according to the disability table of the Danish Labour Market Insurance. The degree of disability can be assessed no earlier than 3 months after surgery
- show indication of surgery, but surgery is not possible due to technical reasons.

The diagnosis is considered made at the date for surgery.

If surgery is not technically possible, it is the date when it is evident from the medical record record from a neurological og neurosurgical ward that an indication of surgery exists, but surgery is not technically possible.

H. Multiple sclerosis
A chronic disease that is clinically characterized by repeated attacks with neurological symptoms from different part of the central nervous system.

The diagnosis must be documented by one or more well-defined attacks of symptoms attributable to multiple sclerosis. Primary progressive multiple sclerosis is also covered. The diagnoses must be confirmed by at least one of the following three examinations:

- Elevated IgG index or oligoclonal bands in the spinal fluid.
- Prolonged VEP latency.
- Typical changes on MRI scan of the central nervous system with multiple affections of the white matter.

The diagnosis is considered made when above-mentioned provisions are met, and a neurologist has made the diagnosis multiple sclerosis.

I. Motor neurone disease (MND)
MND of one of the following types:

- Amyotrophic laterial sclerosis (ALS).
- Progressive bulbar palsy (PBP).
- Progressive muscular atrophy (PMA).
- Primary lateral sclerosis (PLS).

The diagnosis is considered made when a neuroligist has made one of the covered diagnoses.

J. Certain muscular and and neurological disorders
Progressive muscular dystrophy of the types:

- Facio-scapulo-humeral dystrophy.
- Limb-girdle muscular dystrophy.
- Myastenia gravis.
- Hereditary sensory motor neuropathy.
- Inclusion body myositis.

The diagnosis is considered made when a neurologist or a specialist in rheumatology have made one of the covered diagnoses.

K. HIV infection resulting from blood transfusion or occupational exposure
Infection with HIV resulting from blood transfusion received after the insurance's commencement date.

Only persons that are found eligible for compensation related to hiv infection resulting from blood transfusion by the Danish Health Authority meet the provisions for payment from the insurance.

Persons who during performance of their professional duties develop HIV infection due to occupational exposure or exposure to infection of mucous membranes are also covered

To document the transmission of infection it is required that the incident is reported as an occupational injury and a negative HIV test has been performed within the first week after the exposure followed by positive HIV test within the next 12 months.

The diagnosis is considered made when above provisions are met, and an infectious disease doctor has diagnosed HIV.

L. Aids
A disease of the immune system caused by an infection with human immunodeficiency virus (hiv).

The diagnosis must meet the Danish Health Authority's criteria for notifiable aids.

The diagnosis is considered made when above provisions are met, and an infectious disease doctor has diagnosed aids.

If the HIV positive diagnosis is made before commencement of the policy period, the insured party is not entitled to payment according to § 7 L.

M. Chronic kidney disease
Kidney failure to the extent that both kidneys permanently and irreversibly stop functioning, resulting in either permanent dialysis or the performance of a kidney transplant. In case of a planned kidney transplant with deceased-donor kidney, the insured party must be accepted on an active waiting list.

The diagnosis is considered made when permanent dialysis has started.

In case of a kidney transplant from a living donor, the diagnosis is considered made on the date of the performed transplant, and in case of a planned kidney transplant with deceased-donor kidney, the diagnosis is considered made on the date of acceptance on an active wating list.

N. Large organ transplants
Planned or performed organ transplant including heart, lung, liver, pancreas or stem cells/bone marrow where the insured party is the recipient.

In case of a planned organ transplant, the insured party must have been accepted on an active wating list.

The diagnosis is considered made at the date of the transplant. In case of a planned organ transplant it is the date of acceptance on an active wating list. In case of an organ transplant with autologous stem cells/bone marv, the diagnosis is considered made at the date of the performed transplant.

P. Parkinson's disease (paralysis agitans)
Primary Parkinson's disease with the main symptoms of muscle stiffness, tremor or oligokinesia. Symptoms of Parkinson's disease caused by psychoactive drugs are not included.

The diagnosis is considered made when a neurologist has made the diagnosis Parkinson's disease (paralysis agitans).

The diagnosis is covered from 1 January 2002.

Q. Blindness
Total and irreversible loss of vision in both eyes when the visual acuity in the better eye is 1/60 or less.

The diagnosis is considered made when a specialist in eye diseased has assessed and confirmed the loss of vision in the medical record.

The diagnosis is covered from 1 January 2002.

R. Deafness
Total and irreversible hearing loss in both ears with a hearing threshold of 100 dB or more at all frequencies.

The diagnoses is covered from 1 January 2002.

S. Aortic disease
Aortic disease includes:

- An aortic aneurysm of more than 5 centimeters in size.
- An aortic aneurysm that has been operated on.
- Aortic rapture.
- Aortic dissection.
- Total aortic occlusion.

The term aorta includes both the thoracic and abdominal part of aorta, but not its branches.

The diagnoses must be documented by either:

- Ultrasound scanning.
- Echocardiography.
- CT scan or MRI.

In case of an aortic aneurysm, the diagnosis is considered made on the date of surgery, or when the aortic aneurysm exceeds 5 centimeters in size.

In cae of an aortic rapture, aortic dissection or toal aortic occlusion, the diagnosis is consideres made when when it is documented by way of clinical findings and ultrasound, echocardiography, CT scan or MRI.

The diagnosis has been covered since 1 January 2005.

T. Sequelae of brain or brain membrane inflammation
Permanent neurological sequelae of infection in brian, cranial brain roots or brain membranes caused by bacteria, viruses or fungi. The permanent neurological sequelae must have resulted in a disability degree of at least 8 percent according to Labour Market Insurance's disability table.

The diagnosis must be based on:

- Detection of microbes in the cerebrospinal fluid.
- Cerebrospinal fluid examination showing a clear inflammatory response (pleocytosis), including an elevated number of white blood cells and proteins, and potentially supplemented with CT scan/MRI.

The degree of disabilty can at the earliest be assessed 3 months after performed spinal fluid examination which proved the brain or brain membrane inflammation. The degree of disability must be assessed and confirmed by a specialist in neurology or infectious diseases.

When above provisions are met, the diagnosis is considered made after 3 months of the spinal fluid examination that proved the brain or brain membrane inflammation.

The diagnosis is covered from 1 January 2005.

U. Sequelae of borrelia infection or Tick Borne Encephalitis
Long-term or permanent neuroborreliosis caused by a tick bite which has resulted in permanent neurological sequelae. The permanent neurological sequelae must have resulted in a disability degree of at least 8 percent according to Labour Market Insurance's disability table.

The diagnosis must be made on basis of a spinal fluid examinations with specific borrelia infection or Tick Borne Encephalitis (TBE) antibodies.

The degree of disability can at the earliest be assessed 3 months after the performed spinal fluid examination which proved the borrelia infection or Tick Borne Encephalitis (TBE). The degree of disability must be assessed and confirmed by a specialist in neurology or infectious diseases.

When above provisions are met, the diagnosis is considered made after 3 months of the spinal fluid examination that proved the borrelia infection or Tick Borne Encephalitis (TBE).

The diagnosis is covered from 1 January 2005.

V. Severe burns, frostbites or chemical burns
Third-degree burns, frostbites or chemical burns covering at least 20 percent of the insured party's body surface.

The diagnosis is considered made when above provisions are met, and the medical record states an assessment and a confirmation from a burn unit.

The diagnosis is covered from 1 January 2007.

W. Implantation of an ICD (Implantable Cardioverter Defibrillator
Completed implantation of an ICD due to documented previous life-threatening arrhythmia.

Furthermore, performed implantation of an ICD as primary prophylaxis is covered for the following diagnoses:

- Sarcoidosis with cardiac involvement.
- Hypertrophic cardiomyopathy.
- Long QT syndrome.

The diagnosis is considered made at the date of surgery.

Implantation of a standard pacemaker is not covered.

The diagnosis is covered from 1 January 2014, while the diagnoses stated under primary prophylaxis are covered from 1 January 2023.

X. Congestive heart failure
Congestive heart failure with reduced ejection fraction in the left ventricle of 35 percent or less despite optimesed medical treatment. Implantation of an andvanced pacemaker system like cardioverter defibrillator (ICD), biventricular pacemaker (CRT) or long-lasting mechanical heart pump, e.g. Heartmate.

The diagnosis is considered made at the date of surgery when above conditions are met.

Implantation of a standard pacemaker is not covered.

Furthermore, chronic heart failure without implantation of ICD/CRT is covered for the following disease:

- Cardiac amyloidosis.

The diagnosis is considered made when a cardiology specialist has made the diagnosis cardiac amyloidosis.

If the insured party previously has been diagnosed, cf. § 7 B (blood clot in the heart) and/or § 7 C (bypass surgery or angioplasty) and/or § 7 D (heart valve surgery) and/or § 7 W (implantation of an ICD), the insured party is not entitled to a payment according to § 7 X.

The diagnosis is covered from 1 January 2006. Implantation of a long-lasting mechanical heart pump, e.g. Heartmate, is covered from 1 January 2017. The diagnosis cardiac amyloidosis is covered from 1 January 2023.

Y. Idiopathic Pulmonary Arterial Hypertension (IPAH1)
Idiopathic Pulmonary Arterial Hypertension group 1.1 in specific medical treatment aimed at idiopathic pulmonary arterial hypertension.

The diagnosis must be documented and be based on cardiac catheterization.

The diagnosis is covered from 1 January 2023.

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Pensionskassen for Akademikere
Dirch Passers Allé 76
DK-2000 Frederiksberg

www.pplus.dk
kontakt@pplus.dk
+45 3818 8700
CVR no. 19676889