Annex 1

Terms of Reference

Healthcare Insurance and Employee Assistance Programme/Long Term Care Insurance/Travel Insurance (Lot 1); Life Insurance, Work Incapacity and Disability Insurance (Lot 2) (the "Services" and each a "Service")

Background:

The ESM is an international financial institution governed by international public law and located in Luxembourg, which provides its members of staff (currently about 230) with insurance services (the "**Services**") as described in these Terms of Reference. Over the contract period of 2027 to 2032, the number of members of staff is expected to be around 235.

The benefits under these Services consider current levels of coverage, however, the ESM is not obliged to follow them. Affiliation to the Services is mandatory for the members of staff, except in cases of unpaid leave and retirement, and is voluntary for their Dependents and trainees.
The ESM is seeking providers to administer the Services to the benefit of its members of staff, and former members of staff, where applicable, including processing the payment of benefits to the beneficiaries, as applicable, and providing advice to the ESM, where relevant.

The ESM is conducting a tender for the Services, in two lots (the "**Tender**"). The selection of the provider for each lot will be assessed separately; however, the Tender may result in one provider being successful in both lots. The duration of the contract(s) awarded further to this tender will be five (5) years for Lot 1 and four (4) years for Lot 2.

Transition between providers

The preferred provider in each Lot must ensure smooth continuation of the Services. Upon signature of the Contract(s), the selected provider will manage the transition of the Services from the incumbent provider (if applicable) in order to commence the provision of the Services as from the start date of the Contract. At the end of the Contract, the selected provider would also need to support the transition to a new provider, if applicable.

Run-off claims and continuity of reimbursement. The selected provider and, where applicable, the outgoing provider must cooperate to ensure the uninterrupted processing and reimbursement of claims incurred before the transition date but submitted or settled thereafter. All associated costs must be included in the proposed premiums or fees, with no additional charge to the ESM; the estimated switching cost is therefore €0.

Continuity of cover for pre-existing conditions. The selected provider must provide coverage on a medical-history-disregarded basis, without medical underwriting, exclusions, waiting periods or premium loadings arising from pre-existing, chronic or ongoing medical conditions for current insured persons transferring to the new arrangement. Candidates must identify any proposed deviation and its financial impact; compliance with this requirement is intended to avoid any switching-related premium impact.

Implementation and technology integration. The selected provider must perform all implementation activities required for service commencement, including configuration of administration or third-party administrator platforms, secure data migration, establishment and testing of electronic data

interfaces and exchanges, set-up for the billing and payment processes, reporting, and user accesses. All implementation and integration costs must be included in the proposed premiums or fees, with no separate one-off charge to the ESM; the estimated switching cost is therefore €0.

Definitions

Please note that the terms defined in this section apply to each Lot, save where specific clarification is made within the description of that Lot.

"Spouse" – where a member of staff is married or, has a civil or other non-marital partner (of either sex) registered under the laws of any Member State of the European Union.

"Dependent Child" (or **"Dependent Children"** in the plural) means the child or children of a member of staff:

(a) whose maintenance is effectively being provided for by a member of staff;
(b) who is the legitimate, legitimised, recognised natural or adopted child, or stepchild of a member of staff;
(c) who is not gainfully employed; and
(d) who is (i) below age 18, or (ii) below age 26 and on a full-time basis studies or attends a training course or professional apprenticeship, or (iii) is prevented by disability or serious illness from earning a livelihood.

"Dependent(s)" – means a Spouse and/or Dependent Children.

"Normal Retirement Age" – means an individual's 65th birthday.

"Retiree(s)" – means former members of staff who, upon their departure from ESM service, meet the age and years of service criteria set out below.

Age	Minimum Years of ESM Service
65 and above	7
64	8
63	9
55-62	10

"Salary" – means the gross basic salary provided by the ESM for each member of staff, unless specified as an annual salary.

"Occupational Disease" - means any disease in the official table of occupational diseases in Luxembourg and any disease that is predominantly caused by the work of the member of staff for the ESM, and as confirmed by the ESM Medical Advisor.

"Accident(s) at Work" – means accidents sustained while at work and accidents sustained while travelling for work purposes (but not while commuting to work on the usual way taken to or from the workplace).

"ESM Social Security Scheme" – means a scheme of insurance services (life, disability, healthcare, travel and long-term care) contracted by the ESM for the benefit of members of staff, funded by contributions of both the ESM and the members of staff.

Lot 1: Healthcare Insurance and Employee Assistance Programme/Long-Term Care/Travel Insurance

1. Healthcare Insurance and Employee Assistance Programme

ELIGIBILITY

- Active members of staff of the ESM;
- Former members of staff of the ESM who, upon departure from ESM service, either (a) are receiving disability benefits under the work incapacity and disability insurance or (b) meet the age and minimum years of service criteria for Retirees. It is anticipated that over the next five years about 8 people will become eligible for Healthcare Insurance as former members of staff. These persons can choose between four plans as described in the Appendix 1. Once a former member of staff chooses one of these four plans, they cannot change their selection to one of the other plans at a later date. Premiums shall be fully borne by the insured person in this case except in the case of former members of staff receiving disability benefits;
- Dependents of active or former members of staff who elect to be affiliated with the ESM healthcare insurance scheme. Such election is subject to approval by the ESM and, unless exceptionally approved by the ESM, individuals cannot change their selection;
- ESM trainees, where no national or other applicable insurance scheme is available. Such coverage shall be limited to Healthcare Insurance only; trainees shall not be entitled to Long-Term Care Insurance, or Travel Insurance.

Scope

Healthcare Insurance provides eligible members with coverage for expenses arising from healthcare treatment, as described in Appendix 1.

It has been in place since May 2013. Eligible members are **not subject to medical underwriting or exclusions of pre-existing medical conditions and have free choice of medical provider.**

Geographic cover

For active members of staff and their affiliated Dependents, coverage is provided on worldwide basis. However, inpatient treatment in the US is covered only in case of a medical emergency or if the provider's medical board approves in the case of a rare medical condition that the medically necessary treatment is available only in the US. For former members of staff and their affiliated Dependents, coverage is restricted to Europe.

Cover

The Tables of Main Benefits in Appendix 1 describe the detailed elements of Healthcare Insurance which the ESM is seeking to cover throughout the contract term from 1 January 2028 through 31 December 2032 for all eligible members.

The selected service provider shall be responsible for ensuring that the reimbursement conditions and ceilings set out herein are properly applied and complied with, taking into account the individual circumstances of each affiliated member.

Where an affiliated member benefits from any other health insurance coverage, regardless of its origin, the selected service provider must take such coverage into account when processing claims and coordinate reimbursements, accordingly, acting as a complementary insurer while fully complying with the provisions and conditions of the Contract. This is to be completed based on the basis of information and supporting documentation provided by the affiliated member and/or the ESM. The Candidate must ensure complete documentation and require the affiliated member to provide additional information to ensure accurate complementary insurance reimbursements.

Candidates should make explicit any deviations between their proposal and the Tables of Main Benefits (Appendix 1_Table 2), and the reasons for such deviations. The ESM reserves the right to refine the cover applicable during the contract term, in consultation with the selected provider.

Additional reimbursements

If applicable, when the portion of the expenses (excluding dental/optical) incurred by a (former) member of staff and his/her insured Dependents, that is not reimbursed under the healthcare insurance plan exceeds during a calendar year 25% of their (last) gross monthly salary during ESM service, they are entitled to an additional reimbursement in the amount of the non-reimbursed portion of the expenses above 25% of the last gross monthly salary during ESM service, with a maximum up to 150% of defined coverage limits. Such additional reimbursements do not apply for former members of staff and their insured Dependents with a Level B plan as described in the Appendix 1.

Example:

- A staff member has a gross monthly salary of **€8,000**.
- The 25% threshold is therefore:

€8,000 × 25% = €2,000

- During the calendar year, the staff member has eligible healthcare costs.
- After the normal reimbursements under the Healthcare Insurance plan, **€3,200** remains unpaid.
- Dental and optical expenses are excluded from this calculation.

Because the unpaid amount is **€3,200**, and the threshold is **€2,000**, the additional reimbursement may apply only to the part above the threshold:

- **€3,200 - €2,000 = €1,200**

So, the insured person may receive an additional reimbursement of **€1,200**, subject to the cap of **150% of the applicable coverage limits**.

EXCLUSIONS

The **maximum** exclusions of cover are described in Appendix 2. They include the consequences of illnesses, injuries or accidents caused voluntarily by the insured person. Candidates are invited to present the impact on their proposed premiums if this exclusion does not apply. Candidates should make explicit any deviations between their proposal and the exclusions described in Appendix 2, as well as the reasons for such deviations.

GUARANTEE OF PAYMENTS AND NETWORK

The ESM requires the provider to provide guarantee of payments for inpatient treatment of network and non-network healthcare providers. The provider must ensure that they respond to a request for such a guarantee of payment within maximum two days after receipt. The ESM requires the provider to have direct settlement agreements with a wide range of network providers in Luxembourg and the border region (Belgium, France, Germany).

CLAIMS ADMINISTRATION

The provider must ensure that insured individuals can claim reimbursement of expenses quickly and easily. The provider must ensure that they turn around an insured person's reimbursement claim in principle, within five business days on average, and within ten business days as an absolute maximum (following receipt of a legitimate and complete claim). The provider must provide insured persons

with an option to submit their claims online and from a mobile device. In this context, candidates will be asked to present their claims administration procedures and how they ensure regularity of claims administration and prevent fraudulent claims. In addition, candidates will be asked to present their online and mobile application tools, to demonstrate user experience and the claims administration process (e.g. all fields required to submit a claim, ease of use, etc.)

Before executing any reimbursements to insured persons or direct settlements to medical providers, the provider is required to review and determine whether claims and invoices are reasonable and customary. Reimbursements will be settled directly into members' or medical providers' bank accounts.

The Healthcare Insurance has been in place since May 2013 and the annual membership and reimbursement data for the relevant past years are shown in Appendix 3.

DISPUTES RELATING TO DENIED CLAIMS OR DENIED COVERAGE

Insured persons have the right to appeal any denied claim or denied coverage. The provider must have a procedure in place to handle disputes relating to denied claims or denied coverage, including minimum procedural guarantees.

PREMIUMS FOR ACTIVE AND FORMER MEMBERS OF STAFF AND THEIR INSURED DEPENDENTS

Candidates should express their Healthcare Insurance premiums for active and former members of staff and their insured Dependents as a fixed percentage of Salary (or last gross basic salary in the case of former members of staff), as described and based on the demographic assumptions given in the table below.

As noted above, candidates are also asked to present in detail the criteria, formulae and process they would apply for annual adjustments of premiums, if any, over the contract duration of 5 years. Premiums must be based on the technical proposals submitted by the candidates, making explicit any deviations, if applicable, between their technical proposals and the cover described in Appendix 1.

In addition, the selected service provider is required to provide, on a monthly basis, a list of all affiliated members and their insured dependents, together with confirmation of the products in which they are individually enrolled, in an Excel format.

The list shall include both active members and former members who are no longer eligible to participate in the ESM healthcare insurance scheme but have requested continuation of their coverage for a period of six months, renewable once for an additional six-month period, up to a maximum of twelve months in total.

The same information must also be provided in a consolidated format on a quarterly basis.

	Premium rate	**Number of (former) staff**	**(Last) Average monthly salary**
1. Active members of staff and their insured Dependents			
Staff member without Dependent	**x.xx%** of salary	62	€8.0k
Staff member with one Dependent	**y.yy%** of salary	27	€9.1k

	Premium rate	Number of (former) staff	(Last) Average monthly salary
Staff member with more than one Dependent	**z.zz%** of salary	146	€9.9k
2. Former members of staff and their insured Dependents			
Former staff member without Dependents	Level A cover, primary plan: **a.aa%** of last salary	0	N/A
	Level A cover, supplementary plan: **b.bb%** of last salary	0	N/A
	Level B cover, primary plan: **c.cc%** of last salary	0	N/A
	Level B cover, supplementary plan: **d.dd%** of last salary	0	N/A
Former staff member with one Dependent	Level A cover, primary plan: **e.ee%** of last salary	0	N/A
	Level A cover, supplementary plan: **f.ff%** of last salary	0	N/A
	Level B cover, primary plan: **g.gg%** of last salary	0	N/A
	Level B cover, supplementary plan: **h.hh%** of last salary	0	N/A
Former staff member with more than one Dependent	Level A cover, primary plan: **i.ii%** of last salary	0	N/A
	Level A cover, supplementary plan: **j.jj%** of last salary	0	N/A
	Level B cover, primary plan: **k.kk%** of last salary	0	N/A
	Level B cover, supplementary plan: **l.ll%** of last salary	0	N/A

CONTINUATION OPTION(S) FOR FORMER MEMBERS OF STAFF AND THEIR DEPENDENTS

Insured persons who are no longer eligible to participate in the ESM healthcare insurance and do not meet the age and minimum years of service criteria for Retirees mentioned above, have the option to continue the healthcare insurance for themselves and their insured Dependents for a fixed period of 6 months, renewable once for a period of 6 additional months (maximum 12 months in total). Premiums shall be fully borne by the insured person in this case. Candidates shall quote their premium for such continuation option(s) as a fixed amount per month (in €), rather than in percentage of salary, and should detail payment modalities (in which the ESM would not be involved).

PAYMENT OF PREMIUMS

For active members of staff and their Dependents as well as any ESM trainees, premiums are paid by the ESM to the provider(s). For former members of staff and Retirees (as well as their Dependents), premiums are payable by the persons concerned directly to the provider(s) and the provider must directly invoice the former ESM staff and collect payment from them.

EMPLOYEE ASSISTANCE PROGRAMME

ELIGIBILITY

All members of staff of the ESM and ESM secondees (currently 1) and their insured Dependents. In the upcoming contract, ESM trainees may also benefit from the EAP, adding around 15 trainees at a given time in the year to the insured population. The aim of the EAP is to reduce absenteeism and support the overall health and well-being of ESM members of staff (including those with managerial responsibilities), secondees, and their Dependents, as well as to provide immediate support in case of crisis.

COVER

The services shall include clinical counselling sessions (limited up to **12** sessions per issue, per year), crisis intervention, work-life balance support, and management support services. In addition, the services shall include access to health and well-being trainings (e.g. online sessions, Webinars, communications and/or newsletters on workplace health topics.

EAP services shall be available by telephone, online, and through face-to-face consultations. The services shall be accessible globally and on a 24/7 basis.

The EAP shall form part of the ESM healthcare insurance programme. The provider shall develop and implement a plan to promote the use of the EAP for preventive support and as the first point of access for psychological counselling.

Accordingly, the EAP shall be added as a possibility to be a method of the prior approval process for psychological therapy. Employees may first access psychological support through the EAP, hence waiving the prior approval process, or carry out the standard prior approval process. More information on the desired coverage is detailed in the "**Table 3 of Desired Benefits** - **Healthcare Insurance for active members of staff and their Dependents".**

Additional ad-hoc services must include support, possibly on-site, in case of a traumatic event, such as serious injury or death of a member of staff. Moreover, candidate must provide a clear description how to quickly and competently provide on-site support, e.g., in case of a traumatic event, such as serious injury or death of a staff member, on ESM premises in Luxembourg. This support (remote or on-site) must be provided within 1 business day of the request.

In addition, the ad-hoc support services shall include a team of case workers, social workers, and/or medical professionals to provide **case management support** for the administration of, and liaison between, the ESM and staff members on prolonged sick leave exceeding six weeks.

Upon notification by the ESM, the case management team shall conduct an initial review of the case and maintain regular contact with the staff member and the ESM HR throughout the period of prolonged sick leave. The team shall act as the liaison between the ESM, the staff member, and the ESM Medical Advisors; support the development and implementation of return-to-work plans; and provide ongoing communication, coordination, and assistance throughout the case management process.

Providers shall describe their proposed methodology and operating model for delivering employee assistance and managing cases of prolonged sick leave. This shall include, at a minimum, the approach to assessing the likelihood of return to work, communication and follow-up plans, case management processes, and the qualifications and professional profiles (CVs) of the proposed case management and para-medical support staff. Providers shall describe their digital platforms available to ensure confidentiality and for the exchange of sensitive personal data, including medical information.

Service quality reporting is requested by the Provider. Ideally, the Provider can carry out voluntary user feedback surveys (qualitative feedback), to gain insights on the quality of the support provided, in addition to the quantitative statistics of plan usage. The provider must share at least annually, if not quarterly, a report indicating the data of the plan usage (e.g. number of sessions used, generic categories of support, in-person versus online support, etc.).

PREMIUMS

Premiums for the EAP should be expressed as a per person amount (assuming about 605 members covered). The cost of ad-hoc services, including case management should be presented separately, in a per hour or per case price. Candidate must submit a financial offer based on the Commercial Response annexed to this RfP.

Duration

The Insurance has been in place since May 2013. Uptake of the EAP has been historically low with under 5 members using the plan per year. No case management support has been provided in the past, and hence would be a new service as from 1 January 2028.

2. Long-Term Care Insurance

ELIGIBILITY

Members of staff of the ESM are eligible to long-term care insurance as long as they are engaged by the ESM (Normal Retirement Age is 65, maximum retirement age is 70). Retirees are not eligible for this insurance.

Former members of staff placed on the ESM disability scheme due to total disability are eligible to the long-term care insurance below the age of 65, or until the end of the disability.

Insured Dependents of members of staff are eligible to the long-term care insurance but only between the ages of 5 and as long as they are insured under the Healthcare Insurance plan.

BENEFIT

The amount of benefit must be an allowance of €1,500 per month in case of partial or €3,000 per month in case of total dependence.

Partial dependence applies if the member cannot perform at least three out of the six activities of daily living defined hereunder without the assistance of a third person. Total dependence applies if the member cannot perform at least four out of the six activities of daily living defined hereunder without the assistance of a third person; or if the member suffers from a neuropsychiatric disease (such as e.g. Alzheimer's disease or senile dementia) which has been medically assessed by a psychiatrist or a neurologist to score less than 15 on Folstein's "Mini Mental State Examination".

Definition of six activities of daily living: (1) washing: ability to maintain a satisfactory level of personal hygiene in accordance with customary standards. Persons solely requiring assistance for washing their hair will not be recognised as being incapable of washing themselves; (2) feeding: ability to feed oneself the food put at one's disposal, implying the ability to cut the food, to serve a drink, to bring the food to the mouth and to swallow; (3) dressing: ability to dress and undress oneself autonomously, taking into account, if necessary, specially adapted clothes. Persons who are unable to secure a prosthesis by themselves will be considered unable to dress themselves autonomously; (4) mobility: ability to move about on level surfaces, taking into account the help of an adapted aid. Persons who are able to move autonomously by using a stick, crutch, wheelchair or any other type of adapted aid, as being able to be mobile; (5) continence: ability to control bowel and bladder function and to ensure hygienic urinary and faecal secretions, taking into account the availability of sanitary protection or surgical devices. Persons able to partially control their urinary secretions will be considered as being continent; and (6) transferring: ability to move from a bed to a chair/wheelchair or vice versa.

Claims to be in a partial or total state of dependence are assessed by the provider and require approval by its medical advisor. The allowances mentioned above will be paid after the relative deductible period of 90 days, with the start date determined as the day following the date of recognition of the state of dependence by the provider.

Candidates should make explicit any deviations between their proposal and the benefits described in this section, as well as the reasons for such deviations. The ESM reserves the right to refine the cover applicable during the contract term, in consultation with the selected provider.

ANNUAL INCREASE

The monthly allowance is increased by inflation (Joint Luxembourg/Brussels index published by Eurostat in which the allowances and grants are increased) each year on 1 January each year and it ceases when the coverage ends (please see under *Eligibility*).

PREMIUMS

Premiums for the Long-Term Care Insurance should be expressed as a per person amount, assuming that about 655 insured persons between the age of 5 and 65 (or 70 as applicable) are covered. Candidate must submit a financial offer based on the Commercial Response annexed to this RfP.

CLAIMS

The Insurance has been in place since May 2013. Since then, no claims of a long-term allowance have occurred.

3. Travel Insurance

ELIGIBILITY

All members of staff of the ESM are eligible for business and personal travel and insured Dependents for personal travel only.

COVER

The Provider must cover 24 hours a day 7 days a week during business travel and private travel abroad. The current level of coverage is as detailed here below:

Travel risk	**Limit in EUR**
Repatriation/emergency travel services	
Repatriation expenses (cost of transportation to an appropriate hospital or to home country, travel expenses of another person who needs to travel to, remain with, or escort the person)	real expenses
Funeral expenses	up to 7,500
Repatriation of remains and transportation of baggage	real expenses
Family visit	up to 10,000
Pet care	up to 300
Losses, damages	
Lost, stolen or accidentally damaged baggage	up to 2,500
Baggage delay (in excess of 4 hours)	up to 1,500
Monetary losses, e.g., loss of money or fraudulent use of credit cards (only if reported to the police or appropriate authorities within 48 hours of the incident and a written copy of the report is obtained)	up to 1,500
Theft of foreign currency (during, or within 120 hours before and after the trip; only if reported to the police and a written copy of the report obtained)	up to 250
Lost Keys	up to 250, in case of set of keys with max of 750/event
Replacement Travel Documents	up to 1,000
Travel inconvenience	
Reasonable costs of travel delay	250/4h delay with a max of 1,000
Overbooked flight (only if the carrier does not provide alternative transportation within eight hours of the original scheduled departure time)	up to 500
Loss or damage to a rental vehicle (deductible expenses)	up to 1,000, subject to limit for ESM plan as a whole of 25,000
Legal expenses	
Pursuit of a claim for damages or compensation against a third party who has caused a beneficiary physical injury, illness or death	up to 10,000
Legal detention	up to 10,000
Bail bond (advance of funds)	up to 50,000
Court attendance	up to 1,000
Personal liability	

Personal liability to pay damages incurred as a result of causing a bodily injury and/or loss/damage to the property of another person	limit for ESM plan as a whole: 5,000,000 per year
Court attendance	up to 5,000
Medical expenses (Insurer will coordinate for costs also covered under the ESM healthcare insurance plan)	
Hospitalisation	lump-sum of 50/day
Post-hospitalisation convalescence	lump-sum of 50/day
Ongoing medical treatment in home country (only if incurred immediately following the date of return and up to 12 months after return)	up to 25,000
Emergency dental expenses	up to 500
Specified infections disease	
Quarantine in home country upon return from business trip	lump-sum of 500
Quarantine abroad	lump-sum of 50/day
Repatriation by government	up to 500
If unable to return to work (deferment period: 14 days)	lump-sum of 250/week during max. 12 weeks
Rescue and evacuation	
Search and rescue (only if written statement from the applicable rescue authorities involved in the search and rescue is obtained)	Costs incurred
Political risk and natural disaster evacuation	Scheduled transport costs to country of residence, where available, or incurred costs of accommodation (up to 14 days)

The ESM would like to improve certain coverage aspects and therefore request the services under the period from 1 January 2028 through 31 December 2032 to cover the below areas and thresholds. These services shall be considered when presenting the financial proposals:

Travel risk	**Limit in EUR**
Repatriation/emergency travel services:	
Repatriation expenses (cost of transportation to an appropriate hospital or to home country, travel expenses of another person who needs to travel to, remain with, or escort the person) Dispatch of a doctor / indispensable medicines in emergency situations Evacuation to a better equipped healthcare centre Repatriation to better equipped healthcare centre in the home country or country of employment Repatriation of remains and transportation of baggage	real expenses
Funeral expenses	up to 7,500
Family visit	up to 10,000
Pet care	up to 300

Losses, damages:	
Lost, stolen, or accidentally damaged baggage	up to 2,500
Baggage delay (in excess of 4 hours)	up to 1,500
Monetary losses, e.g., loss of money or fraudulent use of credit cards (only if reported to the police or appropriate authorities within 48 hours of the incident and a written copy of the report is obtained)	up to 1,500
Theft of personal items/stolen valuables (during, or within 120 hours before and after the trip; only if reported to the police and a written copy of the report obtained)	up to 1,500 per item
Theft of foreign currency (during, or within 120 hours before and after the trip; only if reported to the police and a written copy of the report obtained)	up to 1,000
Lost Keys	up to 250, in case of set of keys with max of 750/event
Trip cancellation and interruption coverage (for illness, accident, or death of the insured or their family, significant home damage, theft of travel documents by break-in or assault, divorce, separation, or 2nd exam sessions. Premature return in the event of death or serious illness of a relative.	Up to 15,000 per claim and per calendar year in total
Missed departure	up to 750
Extended trip	up to 150 per day, and up to 1,500 per trip
Replacement Travel Documents	up to 1,000
Travel inconvenience:	
Reasonable costs of travel delay	250/4h delay with a max of 1,000
Overbooked flight (only if the carrier does not provide alternative transportation within eight hours of the original scheduled departure time)	up to 1,000
Loss or damage to a rental vehicle (deductible expenses)	up to 1,000, subject to limit for ESM plan as a whole of 25,000
Legal expenses:	
Pursuit of a claim for damages or compensation against a third party who has caused a beneficiary physical injury, illness or death	up to 10,000
Legal detention	up to 10,000
Bail bond (advance of funds)	up to 50,000
Court attendance	up to 1,000
Personal liability	
Personal liability to pay damages incurred as a result of causing a bodily injury and/or loss/damage to the property of another person	limit for ESM plan as a whole: 5,000,000 per year
Court attendance	up to 5,000
Medical expenses (Insurer will coordinate for costs also covered under the ESM healthcare insurance plan):	
Hospitalisation	lump-sum of 50/day
Post-hospitalisation convalescence	lump-sum of 50/day

On-going medical treatment in home country (only if incurred immediately following the date of return and up to 12 months after return)	up to 25,000
Hotel expenses for relatives in the event of hospitalisation abroad	up to 250 per day, for a maximum of 10 days
Emergency dental expenses	up to 500
Specified infections disease:	
Quarantine in home country upon return from business trip	lump-sum of 500
Quarantine abroad	lump-sum of 50/day
Repatriation by government	up to 500
If unable to return to work (deferment period: 14 days)	lump-sum of 250/week during max. 12 weeks
Rescue and evacuation:	
Search and rescue (only if written statement from the applicable rescue authorities involved in the search and rescue is obtained)	Costs incurred
Political risk and natural disaster evacuation	Scheduled transport costs to country of residence, where available, or incurred costs of accommodation (up to 14 days)

Candidates should make explicit any deviations between their proposal and the benefits described in this section, as well as the reasons for such deviations. The ESM reserves the right to refine the cover applicable during the contract term, in consultation with the selected provider.

EMERGENCY EVACUATION

The provider must collaborate with the ESM's third-party provider for non-medical emergency evacuations, International SOS, in particular for scenarios where two members of staff are in the same travel destination, one requiring an evacuation for medical reasons, and another for non-medical reasons (e.g., a riot). Direct invoicing with International SOS shall be put into place for all repatriation services for professional travel. A coordinated approach shall be presented as to working with International SOS on various scenarios of repatriation or emergency rescue.

PREMIUMS

Premiums for the Travel Insurance should be expressed as a per capita amount, assuming that 235 members of staff and 430 insured Dependents are covered. Candidate must submit a financial offer based on the Commercial Response annexed to this RfP.

CLAIMS

The Insurance has been in place since May 2013. Since the past contract has been in place from 1 April 2023, the below claims have been paid (figures in EURO). Prior to this contract period, there were too few claims to provide claim data; hence overall usage of the plan remains conservative throughout time:

Assistance	664.32
Baggage Delay & Loss of Baggage	4,309.87
Medical Expenses/Infectious Diseases	1,847.72

Trip Delay	3,437.52
Grand Total	**10,259.43**

Lot 2: Risk Plan

1. Life Insurance

ELIGIBILITY

All members of staff at the ESM are covered by the ESM's life insurance policy, under which a death benefit is payable in the event the member of staff dies while in the ESM's service. Cover is provided until the member of staff leaves the ESM and is no longer considered a member of staff. Normal retirement age is 65 (and maximum retirement age is 70).

LIFE INSURANCE BENEFIT

- *Normal life insurance benefit:* The amount of lump sum benefit payable is **4 times the annual Salary** for all members of staff affiliated to the ESM social security scheme; or
- *Dependents option*: Members of staff can affiliate their Dependents to the ESM Social Security Scheme, in which case the amount of normal life insurance benefit payable of 4 times the annual Salary is doubled to **8 times the annual Salary**; or
- *Accident(s) at Work or Occupational Disease extra benefit:* in the event the member of staff, who does not have a Dependent affiliated to the ESM Social Security plan, dies while in the ESM's service by accident at work or occupational disease, the amount of normal life insurance benefit payable of 4 times the annual Salary is doubled to 8 times the annual Salary.

The Provider must offer the following life insurance benefits:

Death other than by Accident at Work or Occupational Disease	**Death benefit**
Staff without Dependents	4 x annual Salary
Staff with Dependents who **are not** affiliated to the ESM social security scheme	4 x annual Salary
Staff with Dependents who **are** affiliated to the ESM social security scheme	8 x annual Salary

Death by Accident at Work or Occupational Disease	**Death benefit**
Staff with or without Dependents	8 x annual Salary

The vast majority of staff with Dependents (approx. 95%) at the ESM opt for affiliating their Dependents with the ESM social security scheme.

Candidates should make explicit any deviations between their proposal and the benefits described in this section, as well as the reasons for such deviations. The ESM reserves the right to refine the cover applicable during the contract term, in consultation with the selected provider.

ADVISORY SERVICES

The selected Provider will also provide medical advisory services to determine the cause of death for the payment of the correct level of death benefit.

Premiums

Premiums for Life Insurance should be expressed as a group unit rate based on the monthly sum of Salaries (assuming €***2.04*** million for 235 staff members as from 2028). Any individual loading for

medical reasons should be explained and detailed in the premium information to the ESM.
Candidate must submit a financial offer based on the Commercial Response annexed to this RfP.

CLAIMS
The life insurance has been in place since May 2013 and only one claim of a life insurance benefit has occurred since induction.

FREE COVER LIMIT
A free cover limit of at least €1,500,000 sum insured per member of staff.

EXCLUSIONS
Exclusions are limited to death due to active participation in war or war-like operations.

2. Work Incapacity and Disability Insurance

ELIGIBILITY
All members of staff at the ESM are covered by the ESM's work incapacity and disability insurance scheme, under which an annuity payment is payable in the event of a work incapacity and/or disability. All ESM staff members who have been off work for a continuous period of 16 weeks, and whose absence has been confirmed by the ESM Medical Advisor, must complete a claim for the work incapacity/disability insurance; the process is managed by ESM's HR Rewards & Employment team.

PAYMENT OF THE WORK INCAPACITY/DISABILITY PENSION
An insured member of staff who has been on a work incapacity for a continuous period of 16 weeks due to an accident or illness, and where a claim has been accepted by the provider on advice from the ESM's Medical Advisors and the Provider's Medical Advisors/Medical Board would become eligible for the work incapacity/disability pension. While the staff members are on prolonged sick leave but employed by the ESM, the payment of the pension is reverted to the ESM as a beneficiary (hence "work incapacity" pension). For the avoidance of doubt, the staff member's salary is paid during their employment period according to the ESM Staff Rules and the Supplemental Rules to the Staff Rules. If a staff member were to no longer be employed by the ESM, but still is confirmed eligible for the disability pension, the staff member would become the beneficiary, and would receive the disability pension in lieu of any professional income (hence "disability" pension).

AMOUNT OF THE WORK INCAPACITY/DISABILITY PENSION
70% of the Salary (the salary immediately prior to the commencement of the incapacity/disability) for the duration of the work incapacity/disability, plus an amount equivalent to 23.33% of the Salary to be added to the ESM Retirement Plan. For the avoidance of doubt, the portion corresponding to 23.33% of the Salary shall only become payable upon termination of their contract with the ESM, provided that the beneficiary remains eligible for the disability pension at that time, as the ESM staff remains affiliated under the ESM Retirement Plan at during any period of work incapacity during their employment.

The work incapacity/disability pension will be payable pro rata in circumstances where the member of staff returns to work on a reduced hour basis (of at least 50% of their working time). Shall the ESM staff member only be capable to return on a reduced hour basis, the work incapacity/disability pension shall be paid in line with their reduction of working time.

DURATION OF THE PAYMENT

From the start of week 17 to the end of week 156 following the first day of continuous absence from work, the pension is normally payable to the ESM (except in case of a permanent and total disability; in which the ESM staff members' contract is terminated, and which the pension would be due to them).

From the start of week 157, upon notification from the ESM, the disability pension is payable directly to the individual until retirement subject to agreement with the provider and their medical advisors.

ESCALATION OF THE WORK INCAPACITY/DISABILITY PENSION

The work incapacity/disability pension increases in line with inflation (Joint Luxembourg/ Brussels index published by Eurostat in which the allowances and grants are increased).

ADVISORY SERVICES

The provider is required to provide medical advisory services to determine full or partial incapacity cases for the payment of the correct level of benefit. The medical advisory board shall provide a short overview of the claim, without any medical data.

The summary shall state:

- **whether the claim is accepted or rejected for coverage;**
- **whether the incapacity or disability is partial or total;**
- **whether the incapacity or disability is temporary or permanent; and**
- **where applicable, the recommended review date or review interval, such as every six months, one year or two years.**

PREMIUMS

Premiums for the work incapacity and disability insurance should be expressed as a unit rate based on the monthly sum of Salaries (assuming €2.04 million for 235 staff members as from 2028). Candidate must submit a financial offer based on the Commercial Response annexed to this RfP.

CLAIMS HISTORY

The work incapacity and disability insurance has been in place since May 2013. The claim information is as below underlined:

2018-2022: 120,150 € total in work incapacity insurance (no disability claims).

2023-2026: 1 on-going case of work incapacity (no disability claim yet), which has a total financial provision of 2.45 million € until the staff reaches 65 years of age. For the sake of clarity, this is a possible financial liability as projected by the insurer and is not an expressed payment or total liability, pending the duration of the work incapacity/disability.

FREE COVER LIMIT

A free cover limit of at least €1,500,000 sum insured per member of staff.

EXCLUSIONS

Insurance coverage will not be applicable if it is due to at least one of the following exclusions:

War or riot; crime or tort; deliberate act; influence of drink or drugs; nuclear accident and radioactivity risks; cause not clinically substantiated (The payment of disability benefits is limited to 36 months if the claim is the result of an illness that is not clinically substantiated, such as mental illness. This time

limit does not apply if the member is admitted to a duly approved hospital or a psychiatric institution specialising in the treatment of similar illnesses).

Candidates should make explicit any deviations between their proposal and the benefits or exclusions described in this section, as well as the reasons for such deviations. The ESM reserves the right to refine the cover applicable during the contract term, in consultation with the selected provider.

Appendix 1 – Description of coverage under Healthcare Insurance

All benefits are valid per insured person and per insurance period (unless otherwise stated). There is no overall ceiling of cover per insured person and per calendar year, however, all benefits are subject to the limits and ceilings mentioned in the following Tables of Main Benefits and exclusions mentioned in Appendix 2. All benefits with a defined duration limitation shall be managed under the GLA-fixed cycle method. The benefit period shall be calculated from the enrolment anniversary date (1 January 2028, or the letter of engagement start date if later) of the eligible member for the respective benefit. At the beginning of each new benefit cycle, the benefit limit shall automatically be renewed and reset. All benefits must be prescribed by a qualified and registered medical doctor, unless mentioned otherwise. Medical treatment, including diagnostic/preventive treatment and prescription drug services, are covered only if consistent with the diagnosis and customary medical treatment for a covered illness or injury; in accordance with general standards of good medical practice, consistent with current standards of professional medical care, of proven medical benefit; not for the sole convenience of the insured person, the doctor or the medical provider; not for aesthetic purposes; and not of an experimental and/or investigational nature. Only reasonable and customary charges are covered. “Prior approval” means that the insured person must provide the provider with specific medical information before the treatment takes place so that the provider’s Medical Board can verify whether the treatment shall be covered under the healthcare insurance plan.

Table 1 below sets out the current coverage levels under the ESM healthcare plan.

Table 2 sets out the requested coverage levels for the upcoming contract.

Candidates are requested to submit one financial offer based on the coverage levels and benefit descriptions set out in Table 2, which will form the basis of the future contract.

For information purposes, the historical claims data and healthcare plan utilisation statistics provided by the ESM relate exclusively to the current coverage levels described in Table 1.

Candidates should therefore take into account the differences between Tables 1 and 2 when preparing their financial offer and explain any assumptions used to assess the impact of the enhanced benefits on pricing.

In addition, Candidates shall clearly identify and explain any proposed deviation from the coverage levels or benefit descriptions set out in Table 2.

The ESM may, from time to time, and subject to its future requirements, consider adjustments to reimbursement percentages, financial ceilings, thresholds, session limits, or other benefit parameters during the term of the future contract. Candidates are therefore requested to describe their methodology for recalculating premiums in the event of such changes. For illustrative purposes, reimbursement levels may vary across benefits and may be adjusted within a range of 80% to 100%, depending on the benefit concerned.

Table 1 of Current Benefits - Healthcare Insurance for active members of staff and their Dependents

ESM HEALTHCARE INSURANCE TABLE OF BENEFITS FOR MEMBERS OF STAFF OF THE ESM AND THEIR AFFILIATED DEPENDENTS			
Service	**Cover**	**Ceiling per Beneficiary**	**Further information**
Inpatient Treatment (Hospital, incl. ICU, or day Surgery or Emergency without overnight at hospital)	**100%**	Worldwide cover. Inpatient Treatment in the US is covered only in the event of an Emergency or if the insurers' medical board approves in the case of a rare medical condition where the Medically Necessary Treatment is only available in the US. In the event of Hospitalisation, the following expenses are covered: • Medical Hospitalisation in public or private facilities, • Hospitalisation and Surgery, • Related medical and paramedical expenses provided in the course of Hospitalisation, • Emergency local transportation of the patient by ambulance. Not covered: costs of organ acquisition or purchase in case of an organ transplant. In case of Hospitalisation, Emergency local transportation of the patient by ambulance is covered within the same country between the patient's residence or the location of the Accident and the nearest Hospital within the same country. Emergency local transportation is also covered if the patient's condition requires a subsequent transfer from the original Hospital to another one nearby.	
Bed and board stay in private room	100%	-	Bed and board expenses for one (1) parent/guardian are also covered where the parent/legal guardian is accompanying an affiliated Dependent child, aged below 16 years old, who is in inpatient Treatment.
Doctor's fees	100%	-	-
Other Services			
Convalescence and rehabilitation rest/ care	100%	up to 28 days up to €45 per day	Only covered if in a recognised centre and when admission is medically motivated following Hospitalisation.
Post-Operative Home Nursing	100%	€90 per hour, or €115 per 24-hour period for a period not exceeding 45 days	Prior approval required, maximum cover of 12 months, maximum reimbursement €2,500.
Nursing fees for home births	100%	up to 10 days	-
Midwife services	100%		1. Preparation sessions: maximum of 6 sessions per pregnancy (medical prescription required) 2. Package for postpartum care at home, covering a duration of 15 days after the birth of the child (no medical prescription required)

ESM HEALTHCARE INSURANCE TABLE OF BENEFITS FOR MEMBERS OF STAFF OF THE ESM AND THEIR AFFILIATED DEPENDENTS			
Service	**Cover**	**Ceiling per Beneficiary**	**Further information**
			3. Intervention during the postpartum period or during breastfeeding, with a medical prescription (medical prescription required)
Cancer treatment	100%	-	-
Outpatient care			
General practitioner / home visit	100%	€75 per visit	-
Specialist practitioner consultation (other than General practitioner); consultation at night / on Sunday / on national holiday/ Emergency at Specialist	100%	€150 per visit	-
Hearing aids	100%	€1,230 per aid per 5-year period starting from date of purchase except in case of change in audiometric conditions	Medical prescription required.
Medical imaging (X-rays, CT scans and MRI)	100%	-	-
Vaccinations	100%	-	Medical prescription required except for vaccination campaigns organised by the ESM.
Dental benefits	100%	€7,670 per period of 24 months.	Includes dental check-ups, fillings, dental prosthesis such as crowns, inlays, onlays, implants & laboratory costs linked to the dental care, as well as Orthodontics treatment started before the age of 18 years old. Prior approval is required for dental prostheses and dental implants and Orthodontics.
Optical benefits	100%	€500 per period of 24 months	Includes prescribed frames and lenses; contact lenses (both prescribed and without prescription) and sunglasses with dioptre. The reimbursement of disposable contact lenses is limited to one pair per day for daily contact lenses and to one pair per month for monthly contact lenses.
Physiotherapy	100%	60 sessions per 12 months.	Prior approval required beyond 40 sessions per Insurance year.
Osteopathy	100%	20 sessions per 12 months.	As per second session, prior approval required, and medical prescription required.
Chiropractic treatment	100%	24 sessions per 12 months.	As per second session, prior approval and medical prescription required.
Acupuncture, aerosol therapy and similar inhalation therapies	100%	30 sessions per 12 months. (max. €40 per acupuncture session)	If performed by a qualified doctor, medical prescription required; if not performed by a qualified doctor, in addition prior approval required.
Homeopathy	100%	-	If prescribed by a qualified doctor or carried out by a qualified doctor, medical prescription required.
Psychotherapy/ psychoanalysis	100%	60 sessions per 12 months. (max. €80 per session).	Medical prescription and prior approval obligatory as from the 6th session. Treatment must be done by a qualified and registered medical practitioner.

ESM HEALTHCARE INSURANCE TABLE OF BENEFITS FOR MEMBERS OF STAFF OF THE ESM AND THEIR AFFILIATED DEPENDENTS			
Service	**Cover**	**Ceiling per Beneficiary**	**Further information**
Psychiatric admission	100%		Prior approval required, unless in the case of an Emergency.
Speech therapy	100%	40 sessions per 12 months.	No prior approval required for a maximum number of 20 sessions per Insurance year. Beyond 20 sessions per year prior approval required.
Fertility treatment	90%	-	Prior approval required. Only covered if essential to help overcome a medical infertility problem. Limited to maximum age of the female being less than 43 years minus 1 day on the start of the treatment. Maximum of 4 fertility treatment cycles. In case pregnancy was interrupted but lasted for at least 26 weeks, 4 additional IVF cycles covered. For same sex couples covered only insofar the partner who wishes to conceive is suffering from a medical infertility problem. Fertility treatment includes Artificial Insemination (AI), Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) and Intra-cellular Sperm Injection (ICSI), including the techniques to obtain the sperm / eggs (MESA, PESA, Cryopreservation, TESA, TESE). Sperm / egg donation and expenses to surrogate mother not covered.
Abortion	-	-	Subject to conditions foreseen under Luxembourg law, including elective abortion. Prior approval required unless in the case of an Emergency.
Radiation, ultrasound therapy	100%	40 sessions per 12 months.	Medical prescription and prior approval required.
Annual preventive check-ups	100%	€850 per 12 months.	Not covered for children.
Orthoptic treatment	100%	-	-
Palliative care			If entitled to full Long-term care benefit (as defined in the table on long-term care insurance benefits): not covered; if entitled to partial long-term care benefit: daily sum of €50; if not entitled to a long-term care benefit: daily sum of €100. Daily sums payable for maximum 6 months.
Funeral expenses			Lump-sum of €3,250.
Pharmacy Expenses - Worldwide cover			
Pharmacy expenses	100%	-	Medical prescription required. Includes prescribed medication and prescribed medical products. If medical prescription is provided, no prior approval is required. Over-the-counter drugs and food supplements are not covered. Vitamins are covered if a blood test shows that the level of a certain vitamin is of such inadequate level that a deficiency disease may develop. Vitamins during pregnancy are covered.

Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents

ESM HEALTHCARE INSURANCE TABLE OF BENEFITS FOR MEMBERS OF STAFF OF THE ESM AND THEIR AFFILIATED DEPENDENTS			
Service	**Cover**	**Ceiling per Beneficiary**	**Further information**
Inpatient Treatment (Hospital, incl. ICU, or day Surgery or Emergency without overnight at hospital)	**100%**	**-**	Worldwide cover. Inpatient Treatment in the US is covered only in the event of an Emergency or if the insurers' medical board approves in the case of a rare medical condition where the Medically Necessary Treatment is only available in the US. In the event of Hospitalisation, the following expenses are covered: • Medical Hospitalisation in public or private facilities, • Hospitalisation and Surgery, • Related medical and paramedical expenses provided in the course of Hospitalisation, • Emergency local transportation of the patient by ambulance. Not covered: costs of organ acquisition or purchase in case of an organ transplant. In case of Hospitalisation, Emergency local transportation of the patient by ambulance is covered within the same country between the patient's residence or the location of the Accident and the nearest Hospital within the same country. Emergency local transportation is also covered if the patient's condition requires a subsequent transfer from the original Hospital to another one nearby.
Bed and board stay in private room	100%	-	Bed and board expenses for one (1) parent/guardian are also covered where the parent/legal guardian is accompanying an affiliated Dependent child, aged below 16 years old, who is in inpatient Treatment. Private rooms shall exclude Junior or Executive Suites.
Doctor's fees	100%	-	-
Other Services			
Convalescence and rehabilitation rest/ care	100%	up to 28 days up to €45 per day	Only covered if in a recognised centre and when admission is medically motivated following Hospitalisation.
Post-Operative Home Nursing	100%	€90 per hour, or €115 per 24-hour period for a period not exceeding 45 days	Prior approval required, maximum cover of 12 months, maximum reimbursement €2,500.
Nursing fees for home births	100%	up to 10 days	-
Midwife services	100%		Preparation sessions: maximum of 6 sessions per pregnancy (medical prescription required)

ESM HEALTHCARE INSURANCE TABLE OF BENEFITS FOR MEMBERS OF STAFF OF THE ESM AND THEIR AFFILIATED DEPENDENTS			
Service	**Cover**	**Ceiling per Beneficiary**	**Further information**
			Package for postpartum care at home, covering a duration of 15 days after the birth of the child (no medical prescription required) Intervention during the postpartum period or during breastfeeding, with a medical prescription (medical prescription required)
Cancer treatment	100%	-	-
Outpatient care			
General practitioner / home visit	100%	€75 per visit	-
Specialist practitioner consultation (other than General practitioner); consultation at night / on Sunday / on national holiday/ Emergency at Specialist	100%	€150 per visit	Including Psychiatrist consultations.
Hearing aids	100%	€1,230 per aid per 5-year period starting from date of purchase except in case of change in audiometric conditions	Medical prescription required.
Medical imaging (X-rays, CT scans and MRI)	100%	-	-
Vaccinations	100%	-	Medical prescription required except for vaccination campaigns organised by the ESM.
Dental benefits	100%	€7,670 per period of 24 months.	Includes dental check-ups, fillings, dental prosthesis such as crowns, inlays, onlays, implants & laboratory costs linked to the dental care, as well as Orthodontics treatment started before the age of 18 years old. Prior approval is required for dental prostheses and dental implants and Orthodontics.
Optical benefits	100%	€500 per period of 24 months	Includes prescribed frames and lenses; contact lenses (both prescribed and without prescription) and sunglasses with dioptre. The reimbursement of disposable contact lenses is limited to one pair per day for daily contact lenses and to one pair per month for monthly contact lenses.
Physiotherapy	100%	60 sessions per 12 months.	Prior approval required beyond 40 sessions per Insurance year.
Osteopathy	100%	20 sessions per 12 months.	As per second session, prior approval required, and medical prescription required.
Chiropractic treatment	100%	24 sessions per 12 months.	As per second session, prior approval and medical prescription required.
Acupuncture, aerosol therapy and similar inhalation therapies	100%	30 sessions per 12 months. (max. €40 per acupuncture session)	If performed by a qualified doctor, medical prescription required; if not performed by a qualified doctor, in addition prior approval required.
Homeopathy	100%	-	If prescribed by a qualified doctor or carried out by a qualified doctor, medical prescription required.

ESM HEALTHCARE INSURANCE TABLE OF BENEFITS FOR MEMBERS OF STAFF OF THE ESM AND THEIR AFFILIATED DEPENDENTS			
Service	**Cover**	**Ceiling per Beneficiary**	**Further information**
Psychotherapy/psychoanalysis	100%	60 sessions per 12 months. (max. €90 per session).	On-going treatments initiated prior to the contract start date may continue under the new contract, provided that a valid medical prescription and prior approval granted during the previous contract period are in place. Such treatments may continue until the approved session limit has been reached. For any treatment commencing under the new contract period, an initial consultation through the Employee Assistance Programme (EAP), pr a prior approval process is required. Eligible treatment must be provided by a duly qualified and licensed medical practitioner, psychologist, or psychotherapist, in accordance with the applicable national registration requirements.
Psychiatric admission	100%		Prior approval required, unless in the case of an Emergency.
Speech and/or Occupational therapy	100%	60 sessions per 12 months (max. €100 per session).	No prior approval required for a maximum number of 20 sessions per Insurance year. Beyond 20 sessions per year a prior approval is required and a medical prescription for such therapy/ies for a medical, developmental, neurological, or behavioural condition.
Fertility treatment	100%	-	Prior approval required. Only covered if essential to help overcome a medical infertility problem. Limited to maximum age of the female being less than 47 years minus 1 day on the start of the treatment. Maximum of 6 fertility treatment cycles. In case pregnancy was interrupted but lasted for at least 26 weeks, 4 additional fertility treatment cycles are covered. For same sex couples covered only insofar the partner who wishes to conceive is suffering from a medical infertility problem. Fertility treatment includes Artificial Insemination (AI), Intra-Uterine Insemination (IUI), In Vitro Fertilisation (IVF) and Intra-cellular Sperm Injection (ICSI), including the techniques to obtain the sperm / eggs (MESA, PESA, Cryopreservation, TESA, TESE). Sperm / egg donation and expenses to surrogate mother not covered.
Abortion	100%	-	Subject to conditions foreseen under Luxembourg law, including elective abortion. Prior approval required unless in the case of an Emergency.
Radiation, ultrasound therapy	100%	40 sessions per 12 months.	Medical prescription and prior approval required.
Annual preventive check-ups	100%	€850 per 12 months.	Not covered for children.
Orthoptic treatment	100%	-	-
Palliative care			If entitled to full Long-term care benefit (as defined in the table on long-term care insurance benefits): not covered; if entitled to partial long-term care benefit: daily sum of €50; if not entitled to a long-term care benefit: daily sum of €100. Daily sums payable for maximum 6 months.
Funeral expenses			Lump-sum of €3,250.
Pharmacy Expenses - Worldwide cover			
Pharmacy expenses	100%	-	Medical prescription required. Includes prescribed medication and prescribed medical products. If medical prescription is provided, no prior approval is required. Over-the-counter drugs and food supplements are not covered. Vitamins are covered if a blood test shows that the level of a certain vitamin is of such inadequate level that a deficiency disease may develop. Vitamins during pregnancy are covered.

1. Table of Main Benefits – Healthcare Insurance for former members of staff and their Dependents

Upon the end of their ESM employment, staff receiving disability benefits under the work incapacity and disability insurance and Retirees who are eligible for retiree coverage may choose between any of the four plans mentioned in the table below.

Service	Cover	Ceiling per person
2.1 Level A	Same coverage as for active members of staff and their Dependents as described in the table above except for limitation of geographical scope to Europe	
2.2 Level B	Same coverage as for active members of staff and their Dependents as described in the table above, except for limitation of geographical scope to Europe and the following	
	Outpatient treatment	**Reimbursement percentage of 80%**
	Inpatient bed and board	100% of semi-private room
	Nursing home / home for the elderly	80% of costs of medical care covered
	Fertility treatment	Not covered
	Palliative Care	80% of the benefits described in the table above for active members of staff and their Dependents
	Dental treatment ceiling	€5,000 per period of 24 months
	Annual deductible[1]	€200 per person or €600 per family per year
	Additional reimbursements as described on page 17	Do not apply
1.3. Complementary Level A plan – as 2.1, but with plan used only for complementary insurance expenses incurred in Europe		
1.4. Complementary Level B plan – as 2.2, but with plan used only for complementary insurance expenses incurred in Europe		

[1] The (first) part of the (eligible) medical expenses not reimbursed by the Insurer and deducted from the amount of (eligible) medical expenses on which the reimbursement is calculated.

Appendix 2 - Exclusions for Healthcare Insurance

Healthcare insurance coverage will not be applicable if it is due to at least one of the following exclusions:

1) The consequences of active participation in war, terrorist activities, or while the beneficiary is carrying out army, naval or air service operations;
2) The consequences of acts that constitute a criminal offence or attempt to commit a criminal offence by the beneficiary;
3) The consequences of illnesses, injuries or accidents caused voluntarily by the beneficiary;
4) The consequences of any accident resulting from the beneficiary's practice of high-risk sports (e.g., parachuting, bungee jumping, sports which involve the use of motorized vehicles; use of aircrafts with no valid certificate of air worthiness);
5) The consequences of practicing sports as a professional sportsperson;
6) The consequences of the practice of any sporting activity in breach of the applicable safety rules in such a way that the beneficiary could not have been unaware of the risk;
7) Nuclear/atomic risk;
8) The consequences of an intentional act of the beneficiary to commit fraud or to submit false reimbursement claims;
9) The consequences of drug addiction/substance abuse;
10) Expenses resulting from treatments rendered by a doctor (i) to himself/herself as the beneficiary or (ii) to a beneficiary that is a close relative of the doctor;
11) Treatment that is considered experimental/investigative according to accepted professional medical standards and treatment that is not medically indicated;
12) Medical services for which a medical prescription is required as per the tables of benefits below and for which such prescription is not provided;
13) Medical services for which prior approval is required as per the tables of benefits and for which such prior approval has not been requested or refused. If prior approval was requested but not answered by the insurer in a timely manner in line with appendix 2, such claims are excluded only if requests are subsequently refused by Henner and the treatment concerned has not been rendered yet;
14) Complementary (and or alternative) treatments that are not in accordance with general standards of good medical practice;
15) Facilities for the aged, primarily giving custodial, educational and rehabilitory care;
16) Cosmetic/aesthetic treatment except restorative treatment following accident or illness;
17) Remedial teaching (speech therapy as described in the table of benefits is not excluded);
18) Sunglasses without dioptre (i.e. solely protecting against the sun);
19) Fluid for contact lenses;
20) Lifestyle products, dietary products, food supplements, nutritional supplements and food products, baby food, mineral waters, tonics, cosmetic products;
21) Sterilisation or reversal of sterilisation;
22) Smoke cessation products and nicotine substitutes;
23) Cryopreservation of sperm or egg cells that is not medically necessary for each component of an infertility treatment;
24) Blood pressure meters, except in case of specific medical conditions;
25) Melatonin;
26) Immunomodulation therapy or micro-immunotherapy;
27) Laser therapy for the treatment of orthopaedic problems;
28) Platelet rich plasma (prp);
29) Thermal cures and spas.

Appendix 3 - Healthcare insurance membership and reimbursement data

Membership by age group

Age group	04/2023-03/2024	04/2024-03/2025	04/2025-03/2026
0-20	254	256	258
21-30	25	21	22
31-40	147	137	122
41-50	159	170	180
51-60	45	45	54
61+	15	14	13
Total	643	642	649

Average reimbursements per member by age group (in €)

Age group	04/2023-03/2024	04/2024-03/2025	04/2025-12/2025 (9 months)
0-20	1,302	1,412	1,081
21-30	1,617	1,599	1,336
31-40	1,608	1,667	1,207
41-50	1,739	1,848	1,272
51-60	2,077	1,848	1,529
61+	1,758	1,843	1,223
Total	1,684	1,782	1,275

Reimbursements by country of care in % of total reimbursements

Country	04/2023-03/2024	04/2024-03/2025	04/2025-12/2025 (9 months)
Austria	0.45%	2.48%	0.91%
Belgium	1.23%	1.72%	0.90%
France	2.59%	1.10%	1.77%
Germany	15.18%	10.52%	11.00%
Greece	1.93%	2.08%	2.96%
Italy	4.84%	3.77%	2.17%
Luxembourg	**64.86%**	**66.87%**	**71.35%**
Spain	2.05%	3.79%	1.59%
Switzerland	0.28%	1.40%	0.35%
United Kingdom	1.15%	2.33%	1.84%
others	*5.44%*	*3.96%*	*5.16%*

Affiliation composition:
Number of dependent children per family: 1.9 for families with children

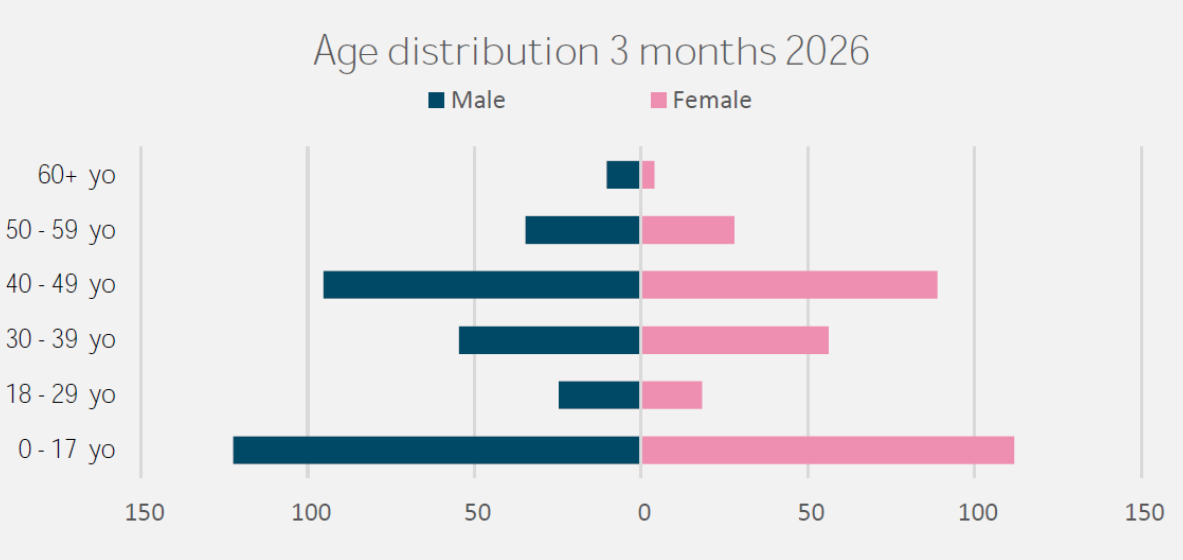
European Stability Mechanism
Demographics history

Number of lives (avg)	Main insured	Spouse	Child	Global	Family coefficient
2023	226	148	264	638	2,83
2024	228	148	262	637	2,80
2025	228	147	267	642	2,82
3 months 2026	231	148	271	649	2,81

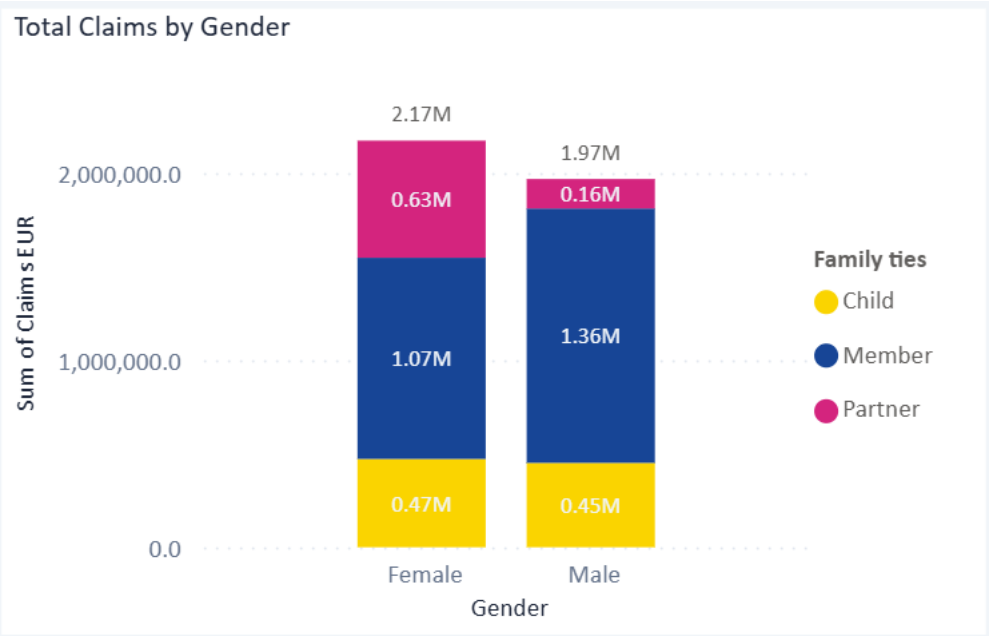
Average age	Main insured	Spouse	Child	Global
2023	42,0	43,0	9,0	28,6
2024	42,4	43,6	9,5	29,2
2025	43,0	44,2	9,8	29,4
3 months 2026	43,2	44,6	10,1	29,7

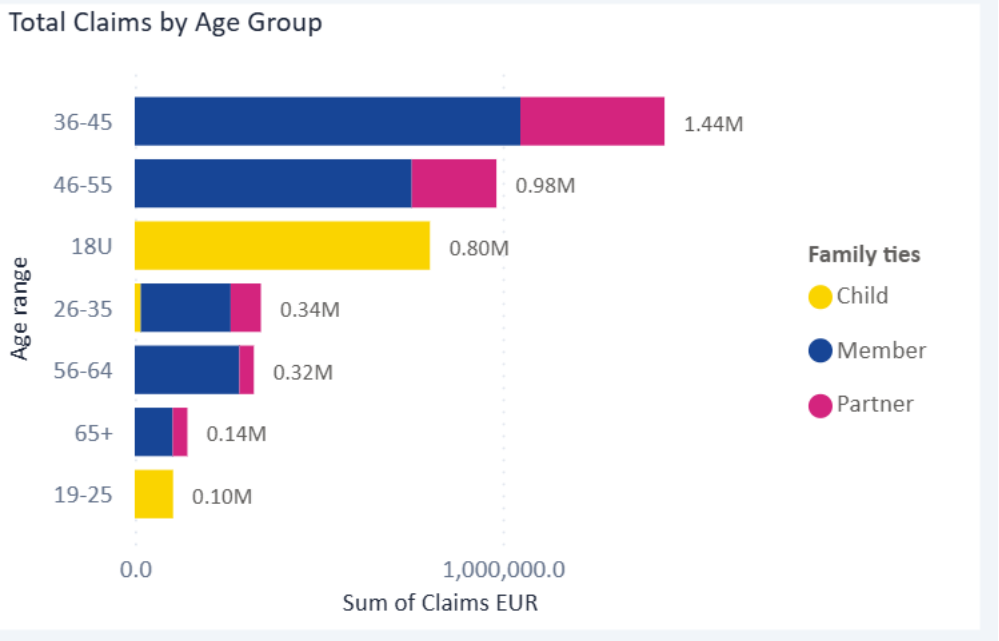
% Male	Main insured	Spouse	Child	Global
2023	63%	37%	53%	53%
2024	63%	39%	53%	53%
2025	61%	40%	53%	53%
3 months 2026	60%	40%	53%	53%

Age and Gender composition (as of 31.03.2026)



Total Claims by Gender and Age Groups (April 2023-December 2025)





High-cost claimant information (April 2023-December 2025):

Claim Range	Number of Claims in Range	Average Claim Size
>20,000€	**1**	**54,143€**
10,001-20,000€	**7**	**13,268€**
5,000-10,000€	**28**	**6,611€**

Expenses by Benefit (As of 31.03.2026):

	Category of treatments	2023	2024	2025	3 months 2026
A	Inpatient	187 347	276 449	122 781	10 857
B	Maternity	58 010	47 793	44 217	182
C	Medical Consultations	218 581	322 221	333 119	52 829
D	Medical auxiliary staff	118 777	222 523	179 714	17 834
E	Laboratory and radiology	179 640	232 124	226 369	42 142
F	Pharmacy	117 630	173 651	227 094	40 991
G	Dental care	155 464	252 287	324 259	42 211
H	Vision care	44 954	45 965	39 896	4 506
I	Miscellaneous	40 446	48 232	58 126	18 320
	Global amount	1 120 848	1 621 245	1 555 576	229 871

	Category of treatments	2023	2024	2025	3 months 2026
A	Inpatient	17%	17%	8%	5%
B	Maternity	5%	3%	3%	0%
C	Medical Consultations	20%	20%	21%	23%
D	Medical auxiliary staff	11%	14%	12%	8%
E	Laboratory and radiology	16%	14%	15%	18%
F	Pharmacy	10%	11%	15%	18%
G	Dental care	14%	16%	21%	18%
H	Vision care	4%	3%	3%	2%
I	Miscellaneous	4%	3%	4%	8%