Questions and Answers 3_ LOT 2		
N°	**Questions**	**Answers**
1	Please confirm the respective roles of the ESM Medical Adviser and the Provider Medical Adviser/Medical Board.	The roles are distinct. After 16 continuous weeks of absence confirmed by the ESM Medical Adviser, the staff member must submit a Work Incapacity/Disability claim. The Provider decides whether to accept the claim on the advice of the ESM Medical Adviser and the Provider's Medical Adviser/Medical Board. The Provider's medical advisers or Medical Board determine whether the incapacity or disability is partial or total and establish the benefit level, taking account of the ESM Medical Adviser's assessment and the member's functional capacity. Dependency relates to Long-Term Care under Lot 1, not Lot 2. References: Annex 1 – Terms of Reference, Lot 2, "Work Incapacity and Disability Insurance" – "Eligibility", "Payment of the Work Incapacity/Disability Pension" and "Advisory Services"; Clarification 2 Lot2 2.pdf, Question 4 (PDF page 2).
2	In the event of differing medical opinions, please clarify which assessment prevails regarding eligibility, degree of disability/incapacity/dependency and continuation or cessation of benefits.	No medical opinion automatically prevails for every issue. For Work Incapacity/Disability claims, the Provider decides claim acceptance under the policy on the advice of the ESM Medical Adviser and the Provider's Medical Adviser/Medical Board. The Provider's medical advisers or Medical Board determine the partial or total degree and benefit level, taking account of the ESM Medical Adviser's assessment and functional capacity. For an occupational disease not expressly listed, confirmation by the ESM Medical Adviser is required. Any unresolved disagreement must be handled under the procedure agreed in the final contract. Dependency is governed separately under Lot 1 Long-Term Care. References: Annex 1 – Terms of Reference, Lot 2, "Work Incapacity and Disability Insurance" – "Payment of the Work Incapacity/Disability Pension" and "Advisory Services"; Clarification 2 Lot2 2.pdf, Question 4 (PDF page 2); Clarification 3 Lot 1 1.pdf, Question 5 (PDF page 2); Request for Proposal, section 3.10, "Contract Terms and Conditions".
3	Please confirm whether a formal dispute resolution or independent medical review process exists.	The tender documents do not establish a separate independent medical appeal process. The Provider's Medical Adviser or Medical Board performs the medical assessment required for the claim. Candidates may propose a medical-review or escalation procedure in their Candidate Terms. It will apply only if accepted by the ESM and included in the final Agreement. References: Annex 1 to the RFP – Terms of Reference, Lot 2, section 2, "Work Incapacity and Disability Insurance" – "Advisory Services"; Request for Proposal, section 3.10, "Contract Terms and Conditions"; Questions and Answers 1 _Lot1.pdf, Questions 24–26 (PDF page 3), which confirm Provider-led Long-Term Care assessment but do not establish an independent appeal process.

N°	Questions	Answers
4	Please confirm whether the Provider may request an independent medical examination if considered necessary.	The tender documents do not expressly grant the Provider a separate right to require an independent medical examination. Clarification 2, Lot 2, Question 4 confirms that the Provider's Medical Adviser or Medical Board assesses the degree of Work Incapacity or Disability, taking account of the ESM Medical Adviser's assessment and the member's functional capacity. References: Clarification 2 Lot2 2.pdf, Question 4 (PDF page 2); Request for Proposal, section 3.10, "Contract Terms and Conditions".
5	Please confirm the medical decision-making hierarchy for Work Incapacity, Disability and Long-Term Care claims. In the event of a difference of opinion between the ESM Medical Adviser and the Provider's Medical Adviser/Medical Board regarding eligibility, degree of disability/dependency, continuation of benefits or occupational disease status, which determination shall prevail and what dispute-resolution mechanism applies?	For Work Incapacity/Disability claims, the Provider decides claim acceptance under the policy on the advice of the ESM Medical Adviser and the Provider's Medical Adviser/Medical Board. The Provider's medical advisers or Medical Board determine the partial or total degree and benefit level, taking account of the ESM Medical Adviser's assessment and functional capacity. For an occupational disease not expressly listed, confirmation by the ESM Medical Adviser is required. Long-Term Care and dependency fall under Lot 1. The clarifications do not establish a general rule that one medical opinion prevails in every disagreement, nor do they establish a separate independent appeal process. Any review or escalation procedure applies only if accepted in the final Agreement. References: Annex 1 – Terms of Reference, Lot 2, "Work Incapacity and Disability Insurance" – "Payment of the Work Incapacity/Disability Pension" and "Advisory Services"; Annex 1 – Terms of Reference, Lot 1, "Long-Term Care Insurance"; Clarification 2 Lot2 2.pdf, Question 4 (PDF page 2); Clarification 3 Lot 1 1.pdf, Question 5 (PDF page 2); Request for Proposal, section 3.10, "Contract Terms and Conditions".
6	Please confirm the broad cause categories of disclosed high-cost claims (e.g. cancer, cardiovascular disease, congenital conditions, accidents, maternity complications or other categories) without identifying individuals.	No further breakdown of high-cost claims by broad medical cause will be provided. Given the small insured population and the limited number of high-cost cases, even broad categories could permit identification of individuals when combined with other information. Candidates should use the anonymised aggregate claims and utilisation data supplied in the Terms of Reference and clarifications.
7	Please confirm whether any ongoing high-cost treatment cases are expected to continue during the tender period.	No additional ongoing high-cost treatment case is confirmed beyond the information already disclosed. Historical claims do not establish whether a treatment will continue during the tender or contract period, and no further case-level information will be provided. The specifically disclosed ongoing Lot 2 case is a Work Incapacity case. If it remains eligible when the new contract starts, the successful Provider will take over the pension and continuity must be ensured during transition. References: Annex 1 – Terms of Reference, Lot 2, "Work Incapacity and Disability Insurance" – "Claims History"; Clarification 1, Lot 2, Question 1.

N°	Questions	Answers
8	Please confirm whether the premiums proposed for Lot 2 (Life, Disability and Work Incapacity) are expected to remain fixed throughout the 4-year contract period, or whether annual premium reviews and adjustments are permitted. If premium revisions are permitted, please specify the applicable methodology, timing, triggers and any limits applicable to such revisions.	Candidates must provide unit rates for each contract year from 2028 to 2031. Annual rate changes may be proposed, but the criteria, formula and process must be clearly explained and reflected in the four-year Total Cost. The tender documents do not prescribe specific adjustment triggers, caps or floors. Any proposed mechanism will apply only if accepted by the ESM in the final Agreement. References: Lot 2 Commercial Response; Annex 1 – Terms of Reference, Lot 2, “Premiums”; Request for Proposal, section 3.10, “Contract Terms and Conditions”.
9	Please confirm whether any catastrophe limit, event limit or maximum aggregate liability applies to Lot 2 (Life, Work Incapacity and Disability). If so, please provide the applicable limit, trigger definition and scope of application. If no such limit exists, please confirm whether bidders may propose an alternative offer including a maximum aggregate limit.	The tender documents do not specify a catastrophe limit, event limit or maximum aggregate liability for Lot 2. The EUR 1.5 million free-cover limits apply separately to Life Insurance and Work Incapacity/Disability and are underwriting thresholds, not benefit ceilings or aggregate liability caps. Candidates must therefore price the requested cover without assuming an undisclosed aggregate cap. Any proposed limit would be a deviation from the requested cover and must be clearly identified; it would apply only if accepted by the ESM in the final Agreement. References: Clarification 1, Lot 2, Question 5; Request for Proposal, section 3.10, “Contract Terms and Conditions”.
10	Regarding the disability/work incapacity case with an estimated liability of approximately €2.5 million, please confirm: • the age of the member; • the date of accident/illness and disability commencement date; • the annual salary and benefit basis; • the current annual benefit in payment; • the expected retirement age; • whether the liability and associated reserves will transfer to the successful bidder; and • the methodology and assumptions used to calculate the €2.5 million liability estimate.	The requested personal, medical, salary and payment details will not be disclosed for confidentiality reasons. The amount stated in the Terms of Reference is a projected possible financial provision of approximately EUR 2.45 million until age 65. It is not an amount already paid or a confirmed total liability, because the actual cost depends on the duration and continued eligibility of the case. The underlying actuarial methodology and assumptions will not be provided. If the case remains eligible at the start of the new contract, the successful Provider will take over payment of the pension and continuity must be ensured during transition. The tender documents do not separately confirm a transfer of the incumbent insurer’s accounting reserves. References: Annex 1 – Terms of Reference, Lot 2, “Work Incapacity and Disability Insurance” – “Claims History”; Clarification 1, Lot 2, Question 1.