

Questions and Answers LOT 1

N°	Reference	Questions	Answers
1	Terms of Reference - Appendix 3	Can you please provide detailed demographics data ? Including : - Age (date of birth) / gender / nationality - Repartition of insured by country - Repartition of insured by category : active staff, retirees, non-retired former staff, dependents, etc. - Annual salary by main insured	For confidentiality reasons, the ESM will not provide a head-by-head census containing dates of birth, nationality, country of residence or individual salaries. Candidates should use the anonymised aggregate information below and the data in Appendix 3 of the Terms of Reference. As at 31 March 2026: - Main insured persons: 231; spouses: 148; children: 271; total insured persons: 649. - Average age: main insured persons 43.2 years; spouses 44.6 years; children 10.1 years; overall 29.7 years. - Male proportion: main insured persons 60%; spouses 40%; children 53%; overall 53%. - Membership by age group: 0–20: 258; 21–30: 22; 31–40: 122; 41–50: 180; 51–60: 54; 61+: 13. All ESM staff are based at the ESM's sole location in Luxembourg. A distribution of insured persons by nationality or country of residence is not provided. For context only, the latest country-of-care data in Appendix 3 show 71.35% of reimbursements in Luxembourg, 11.00% in Germany and 17.65% in all other countries combined for April–December 2025; this is not a distribution of insured persons by residence or nationality. Residency or nationality does not have an impact on where staff may seek their medical treatment. Individual annual salaries will not be disclosed. For pricing, the average monthly salary assumptions are EUR 8,000 for staff without Dependents, EUR 9,100 for staff with one Dependent and EUR 9,900 for staff with more than one Dependent, equivalent to annual averages of EUR 96,000, EUR 109,200 and EUR 118,800 respectively. The aggregate monthly salary assumption is EUR 2.04 million for 235 staff members from 2028.
2	Terms of Reference	For each insurance risks (healthcare / long-term care / travel / life), have there been any changes of benefits during the periods for which you provide claims data? If yes, can you please provide details on the applied changes and inform when the changes occurred?	No material benefit changes occurred during the periods covered by the claims data provided for Healthcare, Long-Term Care, Travel or Life Insurance. For clarity: - Healthcare: the historical membership, reimbursement and utilisation data relate to the current coverage levels shown in Appendix 1, Table 1. Over the course of the current contract, only clarifications have been made to coverage levels as now detailed in Appendix 1, Table 1 to clarify and specify the exact coverage conditions such as emergency medical care, midwife care, and psychological care. The enhanced coverage requested for the new contract is shown separately in Table 2 and is not reflected in the historical claims data. Candidates should therefore assess and explain the expected pricing impact of those enhancements. - Long-Term Care: the insurance has been in place since May 2013 and no long-term-care allowance claims have occurred; no historical benefit change affecting claims data has been identified. - Travel: the claims data provided relate to the contract period beginning 1 April 2023 in the first table listed; no benefit change affecting those data has occurred. - Life: the insurance has been in place since May 2013 with no benefit change affecting the claims history has been identified. Any future changes to the coverage during the new contract would be made in consultation with the selected Provider and handled under the contractual premium-adjustment provisions, where applicable.
3	Request for Proposal - 3.10 Contract terms and Conditions	In case of a consortium, it is acceptable if each consortium members provide its own contractual terms ? (i.e. separate contracts)	Yes, this is possible. For all the instructions relating to the Contractual Terms and Conditions and the involvement of third parties, please refer to Articles 3.10 and 4.8 of the RfP.
4	Terms of Reference - Payment of Premiums	It is stated that "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." As ESM is the policyholder of the contract, does the ESM act as guarantor in case of non-payment of premiums by retirees and former staff?	No. ESM does not act as guarantor in case of non-payment.
5	Terms of Reference - Healthcare Insurance	Are you able to provide the amount of claims in the past years that correspond to additional reimbursement based on the threshold of 25% of the gross monthly salary?	Since April 2023, this benefit has not been used.

Questions and Answers LOT 1

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6	Terms of Reference - Travel Insurance	Can you please provide some travel data over the past years ? Including : - Volume of travels / number of travelers - Main destinations of travel	For pricing purposes, candidates should assume that Travel Insurance covers 235 members of staff for business and additionally approximately 430 insured Dependents for personal travel only. The Travel Insurance has been in place since May 2013. Claims paid under the current contract since 1 April 2023 total EUR 10,259.43, comprising: - Assistance: EUR 664.32; - Baggage delay/loss: EUR 4,309.87; - Medical expenses/infectious diseases: EUR 1,847.72; and - Trip delay: EUR 3,437.52. Prior to 1 April 2023, there were too few claims to provide meaningful claims data. No destination breakdown is available.
7	Terms of Reference - Travel Insurance	It is stated that : "The provider must collaborate with the ESM's third-party provider for non-medical emergency evacuations, International SOS,". Does it mean that : - Non-medical assistance is organized by International SOS, and the Provider shall cover the associated costs according to the table of benefits. - Medical assistance shall be organized directly by the Provider	Yes. International SOS is ESM's third-party provider for non-medical emergency evacuations, while the Provider is responsible for medical assistance under the Travel Insurance cover.
8	Terms of Reference - Long-Term Care	Can you please confirm that the long-term care coverage program is also for an initial contract of 5 years?	Yes. The requested service period is from 1 January 2028 to 31 December 2032.
9	Terms of Reference - Long-Term Care	Could you kindly confirm whether the long-term care coverage should be considered as an annual coverage (which means that in case of termination of the contract, no benefits are due for claims occurring after the termination date)?	No. Long-Term Care Insurance should not be considered annual coverage. The monthly allowance is payable after the 90-day deductible period and ceases when the insured person's coverage ends under the applicable eligibility rules.
10	Terms of Reference - Long-Term Care	Can you please confirm that the long term care cover only the following population: a. Members of staff of the ESM as long as they are engaged by the ESM (Normal Retirement Age is 65, maximum retirement age is 70). b. Former members of staff placed on the ESM disability scheme due to total disability below the age of 65, or until the end of the disability. c. Insured Dependents of members of staff only between the ages of 5 and as long as members of staff are insured under the Healthcare Insurance plan. d. Retirees are not eligible to the long term care.	Confirmed. Eligible persons are: (a) ESM members of staff while engaged by ESM, with Normal Retirement Age 65 and maximum retirement age 70; (b) former staff on the ESM disability scheme due to total disability, below age 65 or until the disability ends; and (c) insured Dependents of members of staff from age 5 while they remain insured under the Healthcare Insurance plan. Retirees are not eligible for Long-Term Care Insurance.
11	Terms of Reference - Long-Term Care	Do all dependents in the contract abide by the same definition (i.e. Dependent means a Spouse and/or Dependent Children)?	Yes, correct.
12	Terms of Reference - Long-Term Care	Could you kindly confirm whether the reimbursements under long-term care cease when the member reaches the age of 65 years?	No. Long-term-care benefits do not automatically cease when an insured person reaches age 65. Members of staff remain eligible while employed by ESM, up to the maximum retirement age of 70, which would be the maximum age of coverage. Coverage would also cease in case of disaffiliation from the plan.
13	Terms of Reference - Long-Term Care	Can a member opt-out from the program if he/she wishes to?	No. All ESM members of staff and their elected dependents are affiliated to the programme. They may not opt-out of just the long-term care insurance.
14	Terms of Reference - Long-Term Care	Could you please confirm us that the annual increase (inflation) applies to the ongoing allowance?	Yes, the monthly long-term-care allowance is increased by the specified inflation index each year on 1 January and ceases when coverage ends.
15	Terms of Reference - Long-Term Care	Could you kindly confirm our understanding of the annual increase is: a. 3000 € per month the year in which the claim occurred and; b. Inflation increase per year in the following years.	Partly confirmed. The initial monthly allowance is EUR 3,000 for total dependence and EUR 1,500 for partial dependence, payable after a 90-day deductible period from the date recognised by the Provider. That allowance is then increased by the specified inflation index each year on 1 January while coverage continues.
16	Terms of Reference - Long-Term Care	Our understanding is since the implementation of long-term care coverage in May 2013, no claims of a long-term allowance have occurred. If this statement is not accurate, can you please provide us the list of claims with the following informations ? : - Occurrence date of the claim - Date of Birth of the insured person - Close date of the claim if it is the case - Amount paid for the claim	Confirmed. The Long-Term Care Insurance has been in place since May 2013 and that no claims for a long-term-care allowance have occurred since then; consequently, there is no claim list to provide.

Questions and Answers LOT 1

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17	Terms of Reference - Long-Term Care	Could you please confirm that premiums related to long-term coverage can be revised, if necessary, during the initial contract duration?	Price revision will be implemented as follows: - Contract effective date: 1 January 2028. - First revised premium effective date: 1 January 2029. - Price-revision notification deadline: 1 October 2028, three months before the Contract anniversary. - Reference index: the latest officially published index available on the notification date.
18	Terms of Reference - Long-Term Care	In which specific cases is a medical questionnaire required for eligibility to the long-term care benefit ?	No medical questionnaire is requested as a condition of eligibility. Current insured persons transferring to the new arrangement must be covered on a medical-history-disregarded basis, without medical underwriting, pre-existing-condition exclusions, waiting periods or related premium loadings. To claim such benefits, the Provider must determine the medical form and information necessary for the applicant to complete for the Provider to thereafter assess the final eligibility to the benefit, or not.
19	Terms of Reference - Long-Term Care	What are the conditions to be satisfied to affiliate to the long-term care annuity benefit, and who — ESM or the insurer — decides on the affiliation?	Affiliation follows the eligibility rules: ESM staff are mandatorily affiliated while employed, except during unpaid leave and retirement; eligible Dependents may be affiliated voluntarily and must already be insured under the Healthcare Insurance plan.
20	Terms of Reference - Long-Term Care	Is the long-term care allowance paid to the policyholder organization or directly to the insured person?	Directly to the insured person/beneficiary.
21	Terms of Reference - Long-Term Care	Do you confirm that all cases to receive a long-term care annuity shall be directly managed by the Provider?	Yes, the Provider is therefore responsible for claim assessment and administration, subject to the contractual procedures and ESM oversight.
22	Terms of Reference - Long-Term Care	Can you please confirm that the benefits (long-term care annuity) are lifelong benefits, payable as long as the dependency criteria are met?	No. The benefit is not stated to be lifelong irrespective of coverage. Please see answer no. 12.
23	Terms of Reference - Long-Term Care	Is the long-term care annuity cumulative with the retirement pension?	No.
24	Terms of Reference - Long-Term Care	Is the assessment of the state of dependency carried out internally by the ESM or by the Provider?	The assessment is carried out by the Provider and requires approval by the Provider's medical adviser.
25	Terms of Reference - Long-Term Care	Is there a questionnaire to be completed by the treating physician, aligned with the activities of daily living (ADL), or will this questionnaire have to be established by the bidder?	The questionnaire and assessment is to be established and carried out by the Provider.
26	Terms of Reference - Long-Term Care	Can you please confirm that payment of the annuity of long-term care is subject to a full medical evaluation, including the completion of a comprehensive questionnaire on the state of dependency?	A medical assessment is required. The Provider must assess the claimed state of partial or total dependency and its medical adviser must approve it before payment. The Provider is invited to detail their medical assessment procedure for full clarity and transparency.
27	Terms of Reference - Long-Term Care	Can you please confirm that long-term care benefits opened during the contractual period, and which continue to meet the criteria, will remain the responsibility of the same insurer after the end of the contract?	No. An active long-term-care allowance will not remain the responsibility of the same insurer after its contract ends. If the beneficiary continues to satisfy the dependency and eligibility criteria, responsibility for the allowance will transfer to the insurer appointed for the next contract period. The outgoing and incoming Providers must cooperate to ensure an uninterrupted transition and payment of benefits.
28	Terms of Reference - Long-Term Care	Can you please confirm that persons with an ongoing state of dependency at the date of affiliation will not be covered under the new contract (either being covered by the previous insurer or excluded)?	No. A person with an ongoing state of dependency at the date of affiliation must not be excluded solely because the condition is pre-existing or ongoing. Current insured persons transferring to the new arrangement must be covered on a medical-history-disregarded basis, without medical underwriting, exclusions, waiting periods or related premium loadings. Any active long-term-care allowance will transfer to the incoming insurer, subject to continued satisfaction of the dependency and eligibility criteria.
29	Terms of Reference - Long-Term Care	After-Service Maintenance: What are the conditions for maintaining long-term care coverage on an individual basis after the termination of group coverage (e.g., retirement or contract end)?	There is no individual continuation option for Long-Term Care Insurance after group eligibility ends. Coverage is available to members of staff while engaged by ESM; former members of staff on the ESM total-disability scheme below age 65 or until the disability ends; and eligible Dependents from age 5 while insured under the Healthcare Insurance plan. Retirees are not eligible. Consequently, the allowance ceases when the person's eligibility and coverage end. The six-month continuation option, renewable once up to 12 months, applies only to Healthcare Insurance and not to Long-Term Care Insurance.

Questions and Answers LOT 1

N°	Reference	Questions	Answers
30	Terms of Reference - Long-Term Care	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). Can you please confirm where we can find the Joint Luxembourg/Brussels index ?	The allowance indexation uses the arithmetic average of the relevant Luxembourg and Belgium index values published by Eurostat for the applicable reference month, in accordance with the Terms of Reference.
31	Terms of Reference - Long-Term Care	It is stated that “The allowance is increased by inflation (Joint Luxembourg/ Brussels index published by Eurostat in Q3) each year on 1 January each year and it ceases when the coverage ends.” Can you please confirm how to calculate this index? Example for 2021 is it the average of Belgium and Luxembourg inflation rate i.e. (3,2+3,5)/2? https://ec.europa.eu/eurostat/databrowser/view/tec00118/default/table?lang=fr	The indexed Long-Term Care allowance is calculated as follows: revised allowance = initial allowance × (IR / I0), where I0 is the arithmetic average of the Luxembourg and Belgium index values for the month in which the Contract entered into force, and IR is the arithmetic average of the Luxembourg and Belgium index values for the applicable reference month. This calculation concerns the Long-Term Care allowance, not the insurance premium.
32	Terms of Reference - Long-Term Care	Former members of staff placed on the ESM disability scheme due to total disability are eligible to Long-term care insurance. Can you please confirm these members profile? how many are they, the nature of disability and how long have they been disabled? Do they currently receive disability benefits? Why are they not receiving long-term care benefits? Can they cumulate total disability and long-term care benefits?"	No Long-Term Care claims have occurred to date. For 2023–2026, there is one ongoing Work Incapacity claim, but this does not establish whether the person satisfies the separate Long-Term Care dependency criteria. Receipt of a Work Incapacity or Disability benefit does not automatically qualify a person for a Long-Term Care allowance. Work Incapacity/Disability and Long-Term Care benefits may be paid cumulatively where both sets of eligibility criteria are independently satisfied and approved by the Provider's medical adviser.
34	Annex 1 - Terms of reference -Definitions	"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 advisor" - Could you please provide us a copy of the table occupational diseases in Luxembourg? - For each case of occupational disease, could you please confirm that the elements on which the ESM Medical advisor relies to make its opinion are shared with the Insurer?	The applicable reference is Luxembourg's official table of occupational diseases, published by the Association d'assurance accident (AAA) under “Maladies professionnelles / Tableau des maladies professionnelles”. The ToR does not reproduce the table. For a case not expressly listed, the disease must be predominantly caused by the member's work for ESM and confirmed by the ESM Medical Adviser. The insurer will receive the determination and the information necessary to assess coverage, but underlying medical records will not be shared automatically. Any disclosure must be limited to what is necessary and comply with medical confidentiality and data-protection requirements; the medical board's report should provide a short determination summary without medical data.
35	Annex 1 - Terms of reference - Lot 1 - 1) Health insurance and Employee Assistance programme	Geographical cover: Could you please confirm the geographical coverage area for trainees please ?	Trainees are eligible for Healthcare Insurance only where no national or other applicable insurance scheme is available. For the purposes of this procurement, their healthcare cover is worldwide on the same basis as for active staff, including the restriction that inpatient treatment in the United States is covered only in an emergency or, for a rare condition, with prior approval from the Provider's medical board. Trainees are not eligible for Long-Term Care or Travel Insurance.

Questions and Answers LOT 1

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36	Terms of Reference - 3. Travel Insurance - Emergency Evacuation	Can you please clarify the services currently provided by International SOS to the ESM ? And clarify what kind of costs from International SOS is expected to be covered by the Provider?	International SOS currently provides ESM's travel-security services, including travel information and advice, security alerts and digital tools, and on-demand emergency evacuation, extraction and crisis-support services. International SOS is ESM's third-party provider for non-medical emergency evacuations. The Travel Insurance Provider must coordinate with International SOS in medical, non-medical and mixed evacuation scenarios and establish direct invoicing with International SOS for all repatriation services relating to professional travel. The Provider is expected to cover the insured repatriation and emergency-travel costs falling within the Travel Insurance table of benefits; ESM's separate subscription and standing service fees payable to International SOS are not transferred to the Provider.
37	Annex 1 - Terms of reference - Lot 1 - Appendix 1 - Description of coverage under healthcare insurance	What is the proportion of persons being reimbursed at first euro and complementary to a basis healthcare system?	All active ESM members of staff are covered on a first-euro basis. Dependents are covered on a first-euro basis where they have no other applicable health insurance; where they have access to a national, employer or institutional scheme, that scheme is primary and the ESM plan acts as complementary cover. Appendix 3 does not provide a reliable numerical split between first-euro and complementary coverage, so no percentage can currently be confirmed.
38	Annex 1 - Terms of reference - Lot 1 - 1) Healthcare insurance and Employee Assistance Programme	"PREMIUMS: "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 member of staff)" 1°) What shall we take as assumption concerning the "last gross basic salary" of former staff as it is indicated "N/A" in the premium table? 2°) On which basis will the premium rate be applied for former member of staff as they do not receive anymore salary but a pension? Or as when the member of staff gets retired, he does not receive anymore salary, could you please confirm whether its premium is invoiced in €, the premium corresponding to the premium rate applied to its last monthly salary?	The "N/A" entries reflect that no former members of staff are included in the current pricing snapshot. For a former member who becomes eligible during the contract, the applicable percentage premium is calculated on the person's last gross basic monthly salary immediately before leaving ESM service, not on the pension. The resulting premium is invoiced directly in euros to the former member by the Provider, based on the selected coverage level and whether the ESM plan is primary or supplementary.
39	Annex 1 - Terms of reference - Lot 1 - 1) Healthcare insurance and Employee Assistance Programme	PREMIUMS: As the number of former staff is of "0" for each category, could you please confirm whether there has been no former staff choosing the plan in the past years?	Confirmed. The current premium-assumption table records zero former members of staff in each category. However, the ToR anticipates that approximately eight persons may become eligible for former-staff Healthcare Insurance during the five-year contract. Their participation will depend on whether they elect an available plan.
40	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Among the main insured, could you please give us the number of member of staff and the number of former member of staff over the 2023-2026 period please? (affiliation composition)	The average numbers of main insured persons reported in Appendix 3 are 226 in 2023, 228 in 2024, 228 in 2025 and 231 for the first three months of 2026. The current premium-assumption table records zero former members of staff; accordingly, these main-insured figures relate to active staff. Separate historical former-staff counts are not available because the population is zero or too small for meaningful disclosure.
41	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Expenses by benefits: Could you please confirm whether the figures correspond: - to full medical expense before reimbursement or, - to the amounts reimbursed to the insured to be sure to retain the right interpretation? This would be great to get both information for the population covered complementary to a first level of reimbursement in order to estimate the proportion of expenses taken in charge by the first level of reimbursement. Could you please provide us with this information ideally by category of treatments? Could you please provide us the same tables by category of treatments for the member of staff on the one hand and for the former member of staff on the other hand over the period 2023-2026?	The figures in the "Expenses by Benefit" tables represent amounts reimbursed under the ESM healthcare plan, not the full medical expenses invoiced before reimbursement. The available data do not separately identify the gross eligible expense, amounts paid by a primary insurer, or the residual amount reimbursed by ESM for complementary cases. The tables are consolidated and cannot currently be provided by both treatment category and first-euro/complementary status, or separately for active and former staff.

Questions and Answers LOT 1

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42	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Could you please provide us a detailed demography including the following information: benefits type (active member of staff or former member of staff / spouse / child), the gender, the birth date, the duty country, the level of coverage (A or B), the level of reimbursement (1st Euro or complementary) and the wage for the member of staff?	For data-protection and confidentiality reasons, ESM will not provide a head-by-head census containing dates of birth, nationality, individual coverage status or salaries. Appendix 3 provides anonymised aggregate data as at 31 March 2026: 231 main insured persons, 148 spouses and 271 children; average ages of 43.2, 44.6 and 10.1 years respectively; and male proportions of 60%, 40% and 53%. All ESM staff have Luxembourg as their duty country. No reliable aggregate split by Level A/Level B or first-euro/complementary cover is currently available, as there are no ESM retirees using this insurance currently. Salary assumptions are provided in the ToR by family category rather than by individual.
43	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Expenses by benefits: Could you please provide us the same tables for the member of staff on the one hand and for the former member of staff on the other hand over the period 2023-2026?	No. The “Expenses by Benefit” tables are available only on a consolidated basis for the insured population. A separate table for active members of staff and former members of staff cannot be provided. The current pricing table records zero former staff, and any very small historical population would also be subject to confidentiality constraints.
44	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Could you please provide us the number of persons being covered at first euro and being covered on a complementary level over the period 2023-2026? This information is important to know whether the proportion of persons per level of reimbursement is stable or not.	The requested annual counts for first-euro and complementary coverage are not available for 2023–2026. Active staff are covered at first euro. Dependents use the ESM plan as complementary cover where another national, employer or institutional scheme applies, and as primary cover where no such scheme exists. ESM began collecting more detailed primary-insurance information for Dependents in 2026, but a validated historical series has not been established.
45	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	High cost claimant information: To be able to use this aggregated information in our analysis, could you please provide us the high claims amount per occurrence ? As claims increased significantly between 2023 and 2024-25, the high claims may explain this increase.	Individual high-cost claim amounts cannot be disclosed because of confidentiality and re-identification risk. Appendix 3 therefore provides aggregate information for April 2023–December 2025: one claim above EUR 20,000, with an amount of EUR 54,143; seven claims between EUR 10,001 and EUR 20,000, with an average of EUR 13,268; and 28 claims between EUR 5,000 and EUR 10,000, with an average of EUR 6,611. No further claim-by-claim breakdown will be provided.
46	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Expense by benefits: Would it be possible to have an update of the claims amount for 2026 occurrence as of End of August 2026? The proposal shall be made for an effect 1st January 2028 and this would avoid to have almost 2 years built on hypothesis (2026 and 2027), 3 months of medical consumption in 2026 being too short a period to allow for proper analysis.	An updated claims extract through 31 August 2026 is not available. The latest figures supplied in Appendix 3 cover the first three months of 2026 and show total reimbursements of EUR 229,871, broken down by treatment category. Candidates should base their proposals on the published data and clearly state any projection assumptions used for the remainder of 2026 and for 2027.
47		Would it be possible for ESM to exclude the travel insurance from the requirement of a 15% cap on annual premium adjustments?	The 15% cap on annual premium adjustments applies only to Healthcare Insurance. No 15% cap applies to Travel Insurance; any adjustment of the Travel Insurance premium will be governed by the separate pricing and adjustment terms applicable to that cover.
48	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Could you please confirm that all member of staff are covered at 1st Euro? And what about the level of coverage for their dependents: are they affiliated at a first level of coverage or reimbursed at 1st Euro for their medical claims?	ESM members of staff are covered under the ESM healthcare plan on a primary, first-euro basis. For Dependents, any applicable national, employer-sponsored or institutional health insurance is primary, with the ESM plan providing complementary cover; where no such insurance applies, the ESM plan provides first-euro cover. A reliable numerical breakdown between first-euro and complementary coverage is not available in the ToR. From 2027, ESM will introduce a strengthened classification procedure to distinguish these coverage types consistently. The data provided pre-date implementation of that procedure.

Questions and Answers LOT 1

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49	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	Could you please confirm that the level of benefits has been the same over the whole 2023-2026 period and that this level of benefits is the same as the one presented in the RFP? Thank you	No material benefit changes occurred during the 2023–2026 claims-data period. The historical claims and utilisation data relate to the current coverage levels in Appendix 1, Table 1. They do not relate to the enhanced benefits requested for the new contract, which are set out in Table 2. Candidates must price the Table 2 benefits and account for the differences from the historical coverage.
50	Terms of Reference - Appendix 2 - Exclusions	In addition to your exclusion list, would it be possible to include certain exclusions from our standard contractual exclusions list ?	The exclusions listed in Appendix 2 constitute the required basis of cover. Additional standard exclusions are not automatically accepted. A Candidate may clearly identify and justify any proposed deviation in its Proposal, but it will be subject to ESM's assessment and agreement and may affect the evaluation. The Proposal should therefore be priced on the basis of the stated exclusions unless ESM expressly accepts a deviation.
51	Request for Proposal - 4.5 Compliance with Law	We understand that all the staff have the supranational status, including trainees, or are exempted of are exempt from any obligation of local social coverage. Could you please confirm our understanding ?	No, this understanding cannot be confirmed. ESM members of staff benefit from the privileges and immunities applicable to ESM under its constituent framework, and are therefore exempt of national social security coverage. Trainees should not be assumed to have the same status or to be exempt from local social-security obligations: under the ToR, they are eligible for ESM Healthcare Insurance only where no national or other applicable insurance scheme is available.
52	Request for Proposal - 4.5 Compliance with Law	Could you please confirm it is acceptable that the insurance contract is governed by the French Law ?	The Candidate may propose an insurance contract governed by French law as part of its Candidate Terms. However, this is not accepted in advance. In accordance with Article 3.10 of the RfP, ESM will review the proposed terms and may request changes. The governing law will therefore be subject to negotiation and the ESM's final acceptance.
53	Terms of Reference	could you please confirm our understanding that although we don't exclude pre-existing conditions, we would only cover claims incurred during insurance period ?	Confirmed, subject to the transition and run-off provisions. Pre-existing, chronic or ongoing conditions must not be excluded, and transferring insured persons must be covered without medical underwriting, waiting periods or related premium loadings. Benefits are payable for eligible claims incurred while the person is covered under the applicable insurance period. Claims incurred before a provider transition but submitted or settled afterwards must continue to be processed under the run-off arrangements; ongoing benefits, including active long-term-care allowances, must transfer without interruption where eligibility continues.
54		In the TOR section "Employee Assistance Programme - COVER", ESM refers to "Table 3 of Desired Benefits - Healthcare Insurance for active members of staff and their Dependents". We have been unable to locate Table 3 within the Terms of Reference or accompanying procurement documents. Could ESM please confirm whether this reference should instead be to "Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents", or could you provide the missing Table 3 if applicable?	Yes, the reference should be instead to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents.
55		Please confirm whether electronic signatures will be accepted under the mentioned requirement ' fully scanned copies with signatures in PDF'? Or could you please further explain what does this requirement entail?	Electronic signatures are accepted.
56		Could ESM provide the distribution of members by city?	Covered by answer no. 1: all ESM staff are based at ESM's sole location in Luxembourg. No further city distribution is available.
57		Can you please share the number of calls and emails volume over the last 5 years, if possible, with a breakdown per language?	The past year shows an average of 105 emails per month, and an average of 22 calls per month. No breakdown by language is available.
58		Referring to Table 1 of Current Benefits - Healthcare Insurance for active members of staff and their Dependents - Does the ESM require an increased coverage or waiver of ceilings of healthcare related reimbursements in case of (occupational) accidents? If so, how would the ESM notify the Candidate on acceptance of occupational accidents?	No, the level of coverage shall be considered in Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents. As most care is at 100% of reimbursements, there is no current increase in coverage needed for ceilings related to occupational accidents.

Questions and Answers LOT 1

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59		Referring to : Lot 1- 2. Long-Term Care Insurance – Annual Increase - The Terms of Reference state that the monthly allowance is increased annually in line with inflation. Could the ESM clarify whether the stated benefit amounts of €1,500 (partial dependence) and €3,000 (total dependence) are fixed throughout the contract period, or whether these amounts will be indexed and adjusted for new as well as existing claims?	Covered by answer no. 14 and answer no. 15: the monthly allowance is indexed each 1 January while coverage continues. The existing answer confirms indexation of ongoing allowances.
60		Referring to : Lot 1 - 3. Travel Insurance – Eligibility of Dependents - The Terms of Reference state that insured Dependents are eligible for personal travel cover. Could the ESM please confirm whether any minimum or maximum age limits apply to dependent coverage under the Travel Insurance plan, or whether all insured Dependents are covered irrespective of age?	Answer no. 11 defines the general ToR definition of Dependents. No further age considerations apply.
61		Referring to Lot 1 - 3. Travel Insurance – Coordination of Coverage - Could the ESM please clarify the intended coordination-of-benefits approach under the Travel Insurance plan, including whether reimbursements received from airlines, travel providers, credit-card insurers, other insurers or liable third parties should reduce the amounts payable under the ESM Travel Insurance coverage? Should insured persons be expected to exhaust alternative sources of recovery before benefits become payable under the ESM Travel Insurance plan?	Benefits under the Travel Insurance plan are intended to indemnify actual eligible losses and expenses and may not result in double recovery. Claimants must disclose any reimbursement or compensation received from an airline, travel provider, credit-card issuer, financial institution, insurer or other liable third party. Any such reimbursement or compensation will be taken into account when determining the amount payable under the Travel Insurance plan, in accordance with the applicable policy terms and conditions. Claimants are not required to exhaust all alternative sources of recovery before submitting a claim; however, any amounts recoverable from or paid by third parties may reduce the benefits payable under the Travel Insurance plan.
62		Could you please provide us with an overview of the number of main insured and lives per month for 2023, 2024, 2025 and up to and including September 2026?	The main insured lives are to be considered as ESM Staff Members, as the data is available in Appendix 3 of the ToR document. Further breakdown by month is not relevant, as there are very minimal fluctuations.
63		Could you please provide us with the incurred claims per month for 2023, 2024, 2025 and up to and including September 2026 with 30/09/2026 as cut-off date?	No monthly claim data will be provided.
64		Could you please provide us with a detailed census list of SM including gender, date of birth, location, nationality, salary and indication if they have dependents?	Covered by answer no. 1 and answer no. 42, and by answer no. 4 in Lot 2: no head-by-head census will be provided; anonymised aggregate demographic and salary assumptions are supplied instead.
65		Could ESM please clarify its expectations regarding medical evacuation services and the role of International SOS (ISOS) under the contract? In particular: a. ~~Is~~ medical evacuation required as a benefit under the proposed insurance coverage? b. ~~What~~ role is ISOS expected to play in the provision and coordination of medical evacuation services? c. ~~What~~ are the specific requirements for coordination between the Candidate and ISOS? d. ~~What~~ responsibilities are expected of the Candidate in relation to medical evacuations? e. ~~Is~~ the Candidate expected only to cover and reimburse the medical and/or logistical expenses associated with medical evacuation, or is the Candidate also expected to arrange and coordinate the evacuation? f. ~~If~~ operational coordination is required, is the Candidate expected to maintain a partnership or formal working arrangement with ISOS, or may the Candidate propose an alternative qualified assistance provider?	Covered by answer no. 7 and answer no. 36: medical assistance and insured medical evacuation are the Provider's responsibility, while International SOS handles non-medical evacuation; coordination and direct invoicing are required for professional-travel repatriation services.
66	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership	What do you advise us to take as average wage increase per year over the 2028-2032 period? (this counter balances the medical inflation rate)	Candidates may assume an approximate annual salary growth equal of between 2-4% (specifically 2.5% estimation indicated in the Commercial Response_Social Security Services), and should clearly state the assumptions used in their five-year pricing.
67	Annex 1 - Terms of reference - Transition between providers	Could you please confirm if the payment of the benefits below are transferred to the new insurer: LTC indemnity ? Incapacity indemnity ? Disability indemnity?	Yes. Active Long-Term Care, Work Incapacity and Disability benefits transfer to the incoming insurer where eligibility continues. The outgoing and incoming Providers must ensure uninterrupted processing and payment.

Questions and Answers LOT 1

N°	Reference	Questions	Answers
68	Annex 1 - Terms of reference - Lot 1 - Appendix 1 - Description of coverage under healthcare insurance	Are the costs related to the vaccination's campaign organized by ESM included in the statistics?	Yes. Costs of vaccination campaigns organized by ESM and covered or reimbursed under the Healthcare Insurance plan are included in the aggregate healthcare reimbursement statistics. ESM currently organizes an annual seasonal influenza vaccination campaign on its premises for staff members only; Dependents are not included in the on-site campaign. Vaccinations obtained individually from a provider are also covered subject to the applicable benefit conditions.
69	Annex 1 - Terms of reference - Lot 1 - Appendix 1 - Description of coverage under healthcare insurance	"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." The only way to accurate in estimating the cost of a benefit's change impact and of course to explain the methodology used is to base the impact's calculation on the proper medical consumption of the ESM. In this purpose, could you please provide us the line by line medical consumption of the ESM population covered over the full 2023-2026 period including the following information: date of care, date of reimbursement, type of medical consumption, full cost of the medical consumption, amount reimbursed, country of consumption, number of acts, currency ? If this information was not available, a rough estimation of the benefit's change could be made within our pricing tools, based on global portfolio statistics, but this could not be explained and the results could be not appropriated to the consumption of your own population. Example: Psychotherapy/psychoanalysis consultation reimbursed 80 € max per session currently => reimbursed 90 € max per session in the table of benefits 2. This type of benefits is supposed to be included in the "medical consultation" or in the "medical auxiliary" expenses (in the statistics provided). However, they are mixed with other types of consultations or acts and we do not know which proportion of these expenses they represent. We cannot guess as well how many persons reach the current ceiling of 80 €. Then the impact is very difficult to estimate without anymore detail.	ESM will not provide line-by-line medical-consumption or claim data. Such data contain confidential health information and, even if direct identifiers were removed, could create a risk of re-identification. The available data for pricing are the aggregate reimbursement and utilisation statistics in Appendix 3, which relate to the current benefits in Table 1. Candidates must assess the impact of the changes in Table 2 using the published aggregate data together with their own actuarial or portfolio assumptions and must clearly explain the methodology and assumptions used, including for individual enhancements such as the psychotherapy reimbursement limit. No additional breakdown by date of care, date of reimbursement, service, full cost, reimbursed amount, country, number of acts or currency will be provided.
70	Annex 1 - Terms of reference - Lot 1 - Appendix 1 - Description of coverage under healthcare insurance	Outpatient treatment are reimbursed at 80% in Plan B. Could you please confirm (as it appears to be classified when reading the TOB) that the following medical expenses are considered as "outpatient treatment": - Psychiatric admission? - Fertility treatment ? - Radiation, ultrasound therapy? - Annual preventive check-ups? - Palliative care? - Funeral expenses?	No. The listed benefits are not all treated as outpatient treatment under Level B: - Psychiatric admission is inpatient treatment. Prior approval is required unless it is an Emergency; the Level B inpatient bed-and-board rule applies. - Fertility treatment is expressly not covered under Level B. - Radiation and ultrasound therapy are outpatient treatment and are reimbursed at 80% under Level B, subject to the stated limit of 40 sessions per 12 months, medical prescription and prior approval. - Annual preventive check-ups are outpatient treatment and are reimbursed at 80% under Level B, subject to the EUR 850 limit per 12 months and the exclusion for children. - Palliative care is subject to the separate Level B rule of 80% of the benefits described for active staff and their Dependents; it is not governed solely by the general outpatient percentage. - Funeral expenses are a separate lump-sum benefit of EUR 3,250 and are not outpatient treatment.
71	Annex 1 - Terms of reference - Lot 1 - Appendix 1 - Description of coverage under healthcare insurance	Could you please confirm "Abortion" is not covered currently? (the benefit is named and a condition is specified but the level of reimbursement is not indicated in table of benefits 1)	Confirmed for the current plan. In Table 1, abortion is listed with the applicable conditions but no reimbursement percentage or amount; it should therefore be treated as not covered under the current benefits. Under the requested benefits in Table 2, abortion is covered at 100%, subject to the conditions under Luxembourg law, including elective abortion, and to prior approval unless it is an Emergency.

Questions and Answers LOT 1

N°	Reference	Questions	Answers
72	Annex 1 - Terms of reference - Lot 1 - Appendix 1 - Description of coverage under healthcare insurance	What are the medical expenses eligible to deductible?	The annual deductible applies only to Level B and Complementary Level B. It is EUR 200 per person, capped at EUR 600 per family per calendar year, and is deducted from the first eligible medical expenses before the applicable reimbursement is calculated. The Terms of Reference do not provide a separate list of expense categories exempt from the deductible; accordingly, it applies to eligible reimbursable medical expenses under Level B. It does not apply to Level A or Complementary Level A, and non-covered expenses or amounts that are not eligible under the table of benefits do not count toward the deductible.
73	Annex 1 - Terms of reference - Lot 1 - 1) Healthcare insurance and Employee Assistance Programme	Geographical cover: Could you please confirm the insurer participates in the "medical board" to the decision in case of a rare case leading to necessary treatment in the USA?	Yes. For inpatient treatment in the United States relating to a rare medical condition, the Provider participates through its medical board. Coverage applies where the Provider's medical board approves that the medically necessary treatment is available only in the United States. In a medical Emergency, U.S. inpatient treatment is covered under the separate emergency condition and does not require approval under the rare-condition route.
74		Referring to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents - Is the exclusion for medical costs in the US only applicable for in-patient care or does it apply to all medical costs including out-patient care and pharmacy expenses?	The restriction applies only to inpatient treatment in the United States. Outpatient treatment and pharmacy expenses remain covered worldwide under the applicable Table 2 reimbursement conditions and ceilings. U.S. inpatient treatment is covered only in a medical Emergency or where the Provider's medical board approves, for a rare medical condition, that the medically necessary treatment is available only in the United States.
75		Referring to Table 2 (Requested Benefits) under Healthcare Insurance for active members and their dependents, could ESM please clarify the application of the EUR 45 ceiling for convalescence and rehabilitation rest/care? Specifically, does this ceiling apply to the overall benefit (including accommodation, care and related services) or only to specific cost components? Furthermore, where continued treatment is medically necessary, would ESM consider an exception to or extension of this ceiling based on approval by the Candidate's Medical Board?	The EUR 45 ceiling applies to the overall convalescence or rehabilitation benefit, per day and per Beneficiary, for up to 28 days. Cover is available only in a recognised centre where admission is medically justified following Hospitalisation. Table 2 provides no automatic entitlement to exceed the EUR 45 daily ceiling or the 28-day limit. ESM may consider an exceptional extension following a reasoned recommendation from the Provider's medical board, but Candidates must price their Proposals using the stated limits.
76		Referring to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents Convalescence and rehabilitation rest/ care in the TOR - Does the ESM provide specific list of recognised centres to the Candidate or can the Candidate apply their own criteria for recognised centres?	ESM will not provide a fixed list of recognised centres. The Provider must determine whether a facility is a duly licensed or otherwise officially recognised convalescence or rehabilitation centre in the country where it operates and whether the admission is medically appropriate following Hospitalisation. The Provider may apply reasonable, transparent recognition criteria consistent with accepted medical practice, but must disclose any additional conditions or limitations in its Proposal and may not narrow the required cover without ESM's agreement.
77		Referring to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents Dental Benefits in the TOR - Does the ESM want to exclude orthodontics for adults in any case, including if IOTN index indicates the treatment to be medically indicated?	Yes. Under Table 2, Dental Benefits include Orthodontics only where the treatment starts before the insured person reaches age 18. Adult orthodontic treatment is therefore not included in the required cover, including where an IOTN assessment indicates medical need. Candidates must price the benefit on that basis; any proposed extension would be a separately identified enhancement and would be subject to ESM's agreement.
78		Referring to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents in the TOR - How does the ESM define dietary products: would medically necessary weight-loss medication be considered a dietary product?	For the exclusion, "dietary products" means products used as food, meal replacements, supplements or nutrition/lifestyle products rather than authorised medicinal products. A medically necessary weight-loss medicine is not treated as a dietary product where it is an authorised medication, prescribed by a qualified medical practitioner for a medically indicated condition and otherwise eligible under the Pharmacy benefit. Over-the-counter products, food supplements and products used solely for lifestyle or cosmetic weight loss remain excluded. Coverage remains subject to the Provider's normal medical-necessity and claims checks.
79		Referring to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents Palliative Care in the TOR - How do plan members claim this benefit currently with the Incumbent? Is this based on plan member claims submitting invoices which are paid 100% up to ceiling per day OR is this a cash benefit paid out based on a confirmation/prior approval via Long Term Care insurance?	Palliative Care is a daily-sum benefit, not reimbursement at 100% of submitted invoices. The applicable amount depends on the person's Long-Term Care status: no Healthcare benefit where the person is entitled to the full Long-Term Care allowance; EUR 50 per day where entitled to the partial Long-Term Care allowance; and EUR 100 per day where not entitled to a Long-Term Care allowance. Payment is limited to six months. The claimant must provide the medical evidence required by the Provider, and the Provider must verify or coordinate the person's Long-Term Care entitlement before paying the applicable daily sum. The detailed claim form and operational process will be agreed with the selected Provider.

Questions and Answers LOT 1

N°	Reference	Questions	Answers
80		Referring to Table 2 Requested Benefits - Healthcare Insurance for active members of staff and their Dependents Funeral Expenses in the TOR - Is this cash benefit paid upon receipt of the death certificate by the plan member? Are there specific requirements and/or coordination efforts with ESM envisaged?	The Funeral Expenses benefit is a lump sum of EUR 3,250; it is not reimbursement of actual funeral invoices. It is payable following notification of the death and submission of satisfactory evidence, normally including the death certificate and the information needed to identify the insured person and the person entitled to receive the payment. The Provider must verify coverage and eligibility and coordinate with ESM where confirmation of affiliation or other administrative information is required. The detailed claim form and payment process will be agreed during implementation.
81		Referring to the Table of Main Benefits – Healthcare Insurance for former members of staff and their Dependents in the TOR - Does 2.2 the Level B option include an annual deductible to be applied for all medical costs or to specific medical costs (such as out-patient care only)?	The annual deductible under Level B and Complementary Level B applies to eligible reimbursable medical expenses generally, not only to outpatient care. It is the first EUR 200 of eligible medical expenses per person, capped at EUR 600 per family per calendar year, deducted before the applicable reimbursement is calculated. Non-covered or otherwise ineligible expenses do not count toward it. This is consistent with answer no. 72.
82		Appendix 2 (Exclusions for Healthcare Insurance) states that claims relating to medical services requiring prior approval may be excluded where such approval was not requested or was refused - Could ESM please confirm whether this provision reflects the current practice under the incumbent arrangement, whether it aligns with ESM's expectations for the future administration of the scheme, and whether candidates should assume that this requirement is intended to be applied strictly throughout the contract term?	Where the table of benefits requires prior approval, the insured person is expected to obtain it before treatment. If approval was not requested or was refused, the claim may be excluded. This requirement reflects current practice and should be applied consistently throughout the contract. However, in justified exceptional cases, including where timely approval could not reasonably be obtained or the Provider did not respond within the applicable timeframe, the Provider may review the claim retrospectively. Any reimbursement remains subject to the Provider's assessment of clinical necessity and the other applicable benefit conditions; retrospective approval is not automatic. The Provider must maintain clear procedures and issue decisions promptly so insured persons are not disadvantaged by administrative delay.
83	Annex 1 - Terms of reference - Lot 1 - Appendix 3 - Healthcare insurance membership and reimbursement data	How do you explain the important medical expenses increase between 2023 and 2024? Were there new benefits in 2024? Is this caused by medical consumption frequency increase or by inflation?	The 2023 insurance year of coverage only started on 1 April 2023 with the current insurer. Hence only 9 months shall be counted for 2023 years versus 2024 as a whole year.
84	Commercial Response_Social Security Services / Lot 1	"Premium adjustments are subject to a maximum yearly cap at 15%." If it allows to propose a more competitive pricing offer, would the ESM be ready to accept different premium adjustment cap than 15% ?	Yes. For Healthcare Insurance, the maximum annual premium-increase cap is 15%. Candidates may propose a lower cap or a more favourable adjustment mechanism, but not a higher cap. The 15% cap does not apply to Travel Insurance.
85	Commercial Response_Social Security Services	What are the hypothesis of repartition of the insured per category: Staff members w/o dependents, Staff members with 1 dependent and Staff member with 2 + dependents?	Please see the current demographics in answer no. 1 and in Appendix 3 of the Terms of Reference.
86	Commercial Response_Social Security Services	Question on the wages in the premium templates: The yearly salary volume used to calculate the 2028 budget is of 24 458 580 €corresponding to the monthly salary volume of 2 038 215 € multiplied by 12 months. The yearly salary volume used to calculate the 2028 health budget is of 25 374 521 € corresponding to the sum of the salaries of the staff members with no dependent, with 1 dependent and with 2 + dependents. Why are the salaries volume different for health and for life benefits?	The salary volumes differ because the Healthcare and Life/Work Incapacity and Disability cost models use separate pricing assumptions. For Healthcare Insurance, premiums vary according to family category, so the model uses separate estimated annual salary masses for staff without Dependents, with one Dependent and with two or more Dependents. These category amounts total EUR 25,374,421.44 for 2028. For Life and Work Incapacity/Disability Insurance, a single unit rate is applied to the aggregate monthly salary mass of EUR 2,038,215 for 235 staff members, equivalent to EUR 24,458,580 annually. Candidates should use the assumptions provided in the relevant Lot template.
87	Annex 1 - Terms of reference - Transition between providers	Is it indeed planned that we will receive the provision related to ongoing claims from the former insurer as of January 1, 2028, for LTC, disability, and invalidity, in order to continue the payment of benefits?	Correct; only for the successful Service Provider, for on-going and relevant cases which would continue as from 1 January 2028.

Questions and Answers LOT 1

N°	Reference	Questions	Answers
88	Annex 1 - Terms of reference - Transition between providers	Similarly, is it indeed planned that we will transfer the provision related to claims that occurred during our coverage period as of December 31, 2031?	The transfer date depends on the applicable Lot. For Work Incapacity and Disability Insurance under Lot 2, ongoing eligible cases would transfer to the incoming Provider from 1 January 2032, following expiry of the Lot 2 contract on 31 December 2031. For Long-Term Care Insurance under Lot 1, ongoing eligible cases would transfer from 1 January 2033, following expiry of the Lot 1 contract on 31 December 2032. Transfers apply only to ongoing eligible cases and require cooperation between the outgoing and incoming Providers to ensure continuity.