General terms and conditions

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GENERAL TERMS AND CONDITIONS

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Contractual basis

The mutual rights and obligations of the parties to the policy are governed by:

- the General Terms and Conditions for all insured risks, as well as the Special Terms and Conditions specific to each cover;
- the Glossary;
- the Special Terms and Conditions and the medical appendixes of the policy, which are legally binding for the promised insurance benefits and for which the insured risk(s) have been indicated.

The mutual rights and duties of the parties to the policy result from the provisions hereof and from the amendments related thereto.

1. Insurance framework

The framework of the cover and respective upper limits of the amounts reimbursed result from the special and general terms and conditions (i.e. the insurance policy) and their amendments as well as Luxembourg legal provisions.

2. General Terms and Conditions

2.1. Existence of the policy

2.1.1. Declarations made upon entering into the policy and throughout its term

2.1.1.1. Upon entering into the policy

The *policyholder* undertakes to answer truthfully and completely all questions the insurer asks. The premium will be set accordingly.

The policy is void due to intentional breach of the obligation to declare that a policy has been taken out, the risk assessment has been changed such that the *insurer*, if said *insurer* had been aware of the unreported circumstances would have, under no circumstances, insured the risk or would have insured it under the same conditions. In such circumstances, the *insurer* shall remain entitled to premiums already paid. The *insurer* has a right of redress for any amounts paid to reimburse claims, as well as a right to pay all premiums due until the *insurer* became aware of the omission or inaccuracy.

If the breach of the reporting obligation is unintentional, the *insurer* may, within one month from the day on which it became aware of the report, propose an amendment to the policy, which would take effect at the time said *insurer* became aware of said breach.

However, if the *insurer* provides proof that in case of a properly reported risk, said *insurer* would under no circumstances have entered into the policy; thereafter, the *insurer* can terminate the policy within one month from the day when it became aware of the breach of the reporting obligation.

If the *policyholder* refuses the proposed amendment or if this proposal is not accepted after a one-month period after receipt of the proposal, the *insurer* may terminate the policy within the next two weeks.

If the breach of the reporting obligation may be the fault of the *policyholder* or the insured party and if a *claim* arises before the termination of the policy is effective, the *insurer* is solely responsible for providing the benefit that according to the ratio between the premium paid and the premium that should have been paid in case of proper reporting of the risk. If the *insurer* provides proof that it would in no way have insured the risk of which the real nature was proved during the *claim*, the benefit related to the *claim* is then limited to the reimbursement of premiums paid and/or fractions of thereof.

If several persons are covered by the insurance relationship and if the conditions of cancellation and/or invalidity are fulfilled only for individual *insured parties*, exercising the above rights may be limited to such persons.

2.1.1.2. During the term of the policy

The *policyholder* and/or the insured party(ies) is/are required to report any changes to the insurance policy that may result in a clear and lasting increase in the insured risk.

2.1.1.3. Cumulative insurance

If another health insurance policy with mandatory benefits exists in addition to this policy, this health insurance shall take precedence over this policy.

2.1.1.4. Right of withdrawal

When the insurance policy is entered into remotely, the *policyholder* shall have a period of 14 calendar days to withdraw from it, without penalty and without providing an explanation or reason.

The period during which the right of withdrawal may be exercised begins to run:

- From the day the distance contract is entered into,
- Or, from the day on which the *policyholder* receives the contractual terms and conditions, if the latter is subsequent to the date referred to in the first indent.

If the *policyholder* exercises his or her right of withdrawal, he or she shall inform about this before the expiry of the period by registered letter or by another durable medium which is at the disposal of the Insurer and to which he or she has access. The deadline is deemed to have been met if the notification has been sent before the expiry of the deadline.

2.1.2. Entry into force and effective date

The insurance takes effect on the date indicated in the Special Terms and Conditions, but not before entering into the insurance policy and not before the end of the waiting periods. The insurance policy shall be deemed to be entered into as soon as it has been signed by both parties to the policy and the *policyholder* has paid the first premium or the first fraction thereof.

No benefits are granted for *claims* occurring before the policy takes effect.

For newborns, health care insurance benefits begin immediately after birth, with no waiting period, without risk assessment, if both parents are *insured* for the cost of care by the *insurer* for at least three months on the date of birth of the child and if the insurance application is received no later than two months after the birth, retroactive for the first of the month of the child's birth. The insurance benefit cannot be higher or more extensive than that of one of the *insured* parents. Newborns can only be insured at the rates provided for in new policies.

2.1.3. Term

The insurance policy starts on the date indicated in the Special Terms and Conditions (policy effective date). The insurance policy is entered into for a period of one year and can thereafter be extended tacitly for a period of one year if it is not terminated within the time period.

2.1.4. Premiums

2.1.4.1. Payment methods

Unless otherwise stipulated, the legally authorised premiums, fees and taxes must be paid in advance to the head office of the *insurer* and/or the agent designated by him or her for this purpose. Payment is required of the *policyholder*.

When the policy covers several insured risks, the total amount of premiums is considered to constitute an indivisible premium.

The premium is an annual premium. It is valid from the effective date of the policy and is due at the beginning of each insurance year. Any amendment to the payment terms requires the agreement of the *insurer*.
The first premium payment must be made at the latest at the time of delivery of the insurance policy.

For insured newborns from birth, premiums are deducted from the day of the child's birth.

2.1.4.2. Consequences for late payment

In the event of non-payment of premiums or a premium payment within ten days of their due date, for any reason whatsoever, the insurance benefits of the policy will be suspended after a minimum period of 30 days subsequent to sending a registered letter to the *policyholder* at his or her last known place of residence. To guarantee its reporting obligation, the *insurer* shall also send the letter to the last known e-mail address.

The registered letter contains a summary by the *insurer* of the past due premium payments. In addition, the letter recaps the due date and the total amount of these premiums, as well as the consequences for non-payment at the end of the aforementioned period.

No *claim* occurring during the suspension period shall be binding on the cover of the *insurer*.

The latter has the right to cancel the policy ten days after the expiry of the aforementioned 30-day period.

The policy that has not been cancelled shall resume its effect going forward at midnight on the day subsequent to the day on which the *insurer* or the agent appointed by it for this purpose receives the payment of the premiums due, or in case of splitting the total amount of the annual premiums, premium fractions that have been subject to the notice of default and premiums that have expired during the period of suspension and, where applicable, legal and recovery costs.

The suspension does not affect the rights of the *insurer* to claim the premiums subsequently due provided that the *policyholder* has been sent formal notice. However, this right is limited to premiums over two consecutive years.
The policy suspended due to non-payment of premiums is automatically terminated after an uninterrupted two-year suspension.

2.1.4.3. Change of rates or terms and conditions

If the *insurer* intends to change the terms and conditions of insurance and/or its rates, it can undertake this change only in accordance with the provisions of the amended law of 27 July 1997 on the insurance policy and any subsequent legal amendments made to said law.

In some cases, if the *insured party* reaches a certain age (for example, during the transition period from childhood and adulthood), the premium corresponding to the highest age group applies from beginning of the calendar year. In this case, the *insurer* is not required to inform the *insured party* in accordance with the provisions of the amended law of 27 July 1997 on the insurance policy and any subsequent legal amendments to the said law.

2.1.5. Benefits

2.1.5.1. Waiting periods

Waiting periods apply during the period when insurance cover is only activated in the event of an accident.

In case of pregnancy (as well as related complications), childbirth, psychiatric benefits, psychotherapy and full dental benefits, waiting times are ten months. In the case of infertility treatment, the waiting time is 24 months for both spouses or partners.

If the policy is amended, the waiting periods also apply to the new portion of the insurance cover.

2.1.5.2. Reporting

In all cases, the *policyholder* and/or the *insured party* must report the *claim* to the *insurer* within three years of its occurrence. If this is impossible due to an unforeseeable event or a case of force majeure, the *insurer* must be notified as quickly as reasonably possible.

2.1.5.3. Obligations and formalities to be completed when making a claim

The *insured party* must immediately take all the necessary measures to avoid a claim or limit the consequences thereof.

The *policyholder* and/or the *insured party* must immediately provide all relevant information to the *insurer* and respond to all inquiries addressed to them to determine the circumstances of the *claim* and determine their extent.

If the *policyholder* and/or the *insured party* do not fulfil one of these obligations and damage is caused to the *insurer*, said *insurer* may be entitled to reduce the benefits it pays out in proportion to the harm it suffered. The *insurer* may refuse its cover if the *policyholder* and/or the *insured party* have not performed their obligations or did so with fraudulent intent.

With regard to insuring health care-related costs, each hospital treatment must be reported within ten days of the start of treatment. In the event of a breach of obligations, the *insurer* may reduce its benefits in proportion to the damage it has suffered. In the event of fraudulent breach of the obligations, the *insurer* may refuse its cover.

The requested information must also be issued to an agent of the *insurer*. At the request of the *insurer*, the *insured party* is required to be examined by a doctor appointed by the *insurer*.

2.1.5.4. Insurer benefits

If there is also entitlement to benefits from a national health insurance fund or if there is entitlement to benefits from another body or institution, the *insured party* must transfer to us all of his or her rights from these organisations.

The *insurer* must only pay if the supporting documents that he or she requests are provided to him or her, said documents shall thereafter become the property of the *insurer*.

The *insurer* reserves the right to archive these documents. The proof of payment provided by the insured party must be original documents, which must comply with the legal provisions of the country issuing the billing. To facilitate receiving the benefits and to reimburse costs quickly, the *insurer* shall also accept sending proof of payment by e-mail or fax, as long as the transmission quality of these documents is high enough for processing them. In the event of a legitimate interest, the *insurer* may request the original supporting documents. If another insurer and/or other institution has contributed to reimbursing costs, duplicate proofs of payment with their original refund description shall be sufficient. The *insurer* may be released from providing its benefits if original supporting documents are provided by a carrier or a shipper.

The following must appear on the invoices: first and last name, as well as the date of birth of the insured person and co-insured, an exact statement of the disease by a doctor (diagnosis) or a precise description of the whole disease or ICD 9 and/or 10 (International Classification of Diseases), individual benefits with treatment data and unit prices. For dental care, the designation of the teeth treated or replaced and the services relating thereto must be indicated.

The following must be included on prescriptions: first and last name, as well as the date of birth of the insured and co-insured parties, the prescribed medication, the price and the payment reference. Prescriptions must be provided with the doctor's note of fees or the bill for medications and remedies.

If the *insured party* requests daily hospitalisation benefits in lieu of reimbursement for costs, he or she must submit a certificate of inpatient treatment, which must include the first and last name, and the date of birth of the person treated, the designation of the disease, days of admission and discharge as well as any days of medical leave.

The *insurer* is entitled to request that the supporting documents be provided on its own forms. The relevant forms must be duly completed by the *insured party* and the attending physician.

The *insurer* is entitled to pay its *benefits* to the person who transmits or sends the supporting documents in due form. In the event of legitimate doubts, the *insurer* shall pay the reimbursement amount to the *policyholder*.

Health care costs incurred in foreign currency shall be converted into euros at the applicable exchange rate on the day the supporting documents are submitted to the *insurer*.

To facilitate processing the supporting documents (e.g. medical reports, invoices, prescriptions) as soon as possible, the *insurer* requests that they be submitted in French, German or English. In addition, the *insurer* recommends using the "Claim Form".

The rights to insurance benefits cannot be transferred or pledged.

2.1.5.5. Subrogation

Unless otherwise agreed, the *insurer* shall be subrogated in the rights and actions of the *insured party* for the amount of compensation paid.

If due to the *insured party* the subrogation can no longer produce its effects for the *insurer*, said *insurer* may claim repayment of the compensation paid out in proportion to the damage it suffered.
Subrogation cannot adversely affect the partially compensated *insured party*. In this case, said party can exercise its preferential rights with respect to the *insurer* for what remains owed to him or her.
Unless the malice of the *insured party* can be proven, the *insurer* shall have no legal recourse against his or her descendants, ascendants, spouse and in-laws in direct line, as well as against those living in his or her home, his or her hosts and household employees. However, the *insurer* may appeal against these persons to the extent that their liability is effectively covered under an insurance policy.

2.1.5.6. Limitation periods

The limitation period for any action arising from the insurance policy is three years. The deadline starts running from the day of the event which is actionable. However, if the person who is entitled to take action can prove that he or she became aware of the event at a later date, the limitation period does not start running until that date and it cannot exceed five years from the event, except in case of fraud. The requirement does not apply to persons unable to act within the prescribed time limit due to force majeure.

If the *claim* has been reported in due time, the limitation is interrupted until the *insurer* has informed the other party of its decision in writing. As for the beneficiary’s action, the period runs from the day on which the beneficiary not only became aware of the existence of the policy and of his or her capacity as beneficiary but the occurrence of the event on which the payability of the insurance benefits is based.

2.1.6. End of policy

No refunds are made on benefits after the end date of the policy, even for *claims* that had already occurred and/or were reported.

2.2. Termination

2.2.1. Automatic termination

A policy suspended due to non-payment of premiums shall be terminated automatically after a continuous two-year suspension.

With regard to the *insured parties* concerned, the insurance policy shall conclude in the event of termination of one of the terms and conditions of insurability stipulated in the rates.

The insurance relationship shall end with the death of the *policyholder*. However, *insured parties* are authorised to continue the insurance relationship by appointing a new *policyholder*, provided that they have reported this within two months following the death of said *policyholder*.

If a divorce has been decreed, the spouses are entitled to continue their portion of the policy as an independent insurance relationship. The same holds true for separated spouses.

2.2.2. Optional termination

In case of multiple covers or insured risks, the cancellation may relate to one or more insurance covers and/or risks.

2.2.2.1. Termination by the *policyholder*

The *policyholder* is entitled to terminate the insurance relationship in its entirety or terminate it for the *insured parties* or rates taken in isolation at the end of each insurance year; however, at the earliest at the end of the contractually agreed period. The cancellation must be sent no later than 30 days before the expiry date of the annual premium, or otherwise 30 days before the anniversary date of the policy effective date. The *policyholder* is also entitled to cancel his or her policy within 30 days from the date of sending the notice of expiry by the *insurer*. The cancellation shall take effect on the second working day following the sending of the cancellation letter, but no earlier than the date of policy renewal.

If the general terms and conditions are changed, the *policyholder* may terminate the insurance relationship for the *insured party* concerned within one month of receipt of the notification of the change as of the effective date of the change.

If the premiums are raised, the *policyholder* is entitled to terminate the insurance relationship of the *insured party* within 60 days of the date of dispatch of the notice of termination by the *insurer*. The cancellation shall take effect on the second working day following the sending of the cancellation letter, but no earlier than the date of policy renewal.

The *policyholder* is entitled to terminate all his or her policies if the *insurer* has terminated one or more insured risks covered by the insurance policy of the *policyholder* or other insurance policy. The cancellation must occur within two weeks of receipt of the report of the *insurer* and shall take effect at the end of the month in which the report is received.

If the *policyholder* terminates the entire insurance relationship or terminates it for the *insured parties* individually, the *insured parties* are authorised to continue the insurance relationship by appointing a new *policyholder*. The notification must occur within two months of the cancellation. The cancellation shall only take effect if the *policyholder* provides proof that the *insured parties* concerned have been informed about the notice of cancellation.

2.2.2.2. Termination by the insurer

If a single insured risk is fraudulently insured by one or more insurance policies with a premium that is too high, the policy shall be null. In this case, the *insurer* may keep the premiums collected.

The *insurer* is entitled to terminate the insurance relationship with immediate effect if the *policyholder* or an *insured party* has obtained or attempted to obtain insurance benefits fraudulently. The right of cancellation shall conclude if it has not been used within one month from the date on which the *insurer* has been informed of the facts prompting the termination.

If the insurance relationship covers more than one person and the terms and conditions of termination have been met only for individually *insured parties*, exercising the aforementioned rights above may be limited to said persons.

2.2.2.4. Bankruptcy of the *policyholder*

In the event of the bankruptcy of the *policyholder*, the insurance policy shall subsist for the benefit of the body of creditors, who becomes debtor of the amount of the premiums to be owed as from the declaration of bankruptcy made to the *insurer*. However, the *insurer* and the trustee in bankruptcy are authorised to terminate the policy. Cancellation by the *insurer* may take place no earlier than three months after the declaration of bankruptcy, and it must be notified within one month after expiry of this period. The trustee in bankruptcy may not terminate the policy until three months after the declaration of bankruptcy.

2.2.3. Policy cancellation

The policy can be cancelled either by registered letter, by writ of a court officer and/or by delivery of the letter of cancellation against receipt.

2.2.4. Repayment of premiums in the case of cancellation

Notwithstanding the cause of termination, the premiums paid for the insurance period after the effective date of cancellation shall be refunded within 30 days of the effective cancellation date. Once this period has expired, statutory interest shall be applied as of right.

2.2.5. End of cover

The cover shall end (the same holds true for *claims* already made) at the end of the insurance relationship.

In the interest of all parties, the Insurer must comply with the international regulations in force. The Insurer is not required to guarantee cover or cover any damages or provide other benefits under this insurance policy, if the execution of the insurance cover, the payment of damages or the provision of a benefit would expose the Insurer to a penalty, prohibition or restriction under United Nations resolutions, to commercial or economic sanctions due to the laws or regulations of the European Union or the United States of America.

2.3. Miscellaneous provisions

2.3.1. Multiple policyholders

If there are several *policyholders*, they are jointly and severally liable for the contractual obligations.

In the event of partial cancellation or any other reduction in insurance benefits, the preceding paragraph applies only for this reduction and in proportion to this decrease.

The *policyholder*, who acts not only in his or her own name, but also in the name and on behalf of the other *insured parties*, authorises the *insurer* to process medical or sensitive data concerning not only his or her person, but also those of other the *insured parties*, if necessary for the pursuit of the aims of this insurance policy.

2.3.2. Notifications

All notifications from the *insurer* to the *policyholder* must be validly sent to his or her last known address. If there are several *policyholders*, each notification of the *insurer* to one of them is considered validly made to all. Notifications made to the *insurer* must be sent to its head office.

2.3.3. Disputes

Should a dispute arise concerning the insurance policy, the *policyholder* must make a written complaint

- **either to the senior management of the *insurer*,**
- **or to the Insurance Ombudsman (c/o: Association des Compagnies d'Assurances (Luxembourg Insurance and Reinsurance Association), 12, rue Erasme, B.P. 448, L-2014 Luxembourg, or to the l'Union Luxembourgeoise des Consommateurs (Luxembourg Consumer Protection Association): 55, rue des Bruyères, L-1274 Howald),**
- **or to the Commissariat aux Assurances (Luxembourg Insurance Commission) (7, Boulevard Joseph II, L-1840 Luxembourg),**

without prejudice to the possibility that the *policyholder* can bring legal action.

2.3.4. Applicable law and competent court

The policy is governed by Luxembourg law. For any dispute arising due to the insurance policy, only the courts of the Grand Duchy of Luxembourg shall be competent, without prejudice to the application of international treaties or agreements.

2.3.5. Local legislation

The insurance cover may be subject in some countries to local health insurance legislation, particularly for the persons residing in those countries. The Policyholder and the Insured party must, under their own liability, check that their health insurance complies with the legal requirements. The insurance cover provided by Foyer Santé is not a substitute for a mandatory health insurance scheme.

2.3.6. Protecting personal data

In accordance with the Law of 1 August 2018 governing the organization of the National Commission for Data Protection and the implementation of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, the Policyholder, acting in their own name or in the name and on behalf of the other insured parties, authorises Foyer Santé to record and process the data communicated thereto, as well as that which shall be communicated thereto at a later date, in order to assess risks, to prepare, create, manage and execute the insurance policy(ies), to settle any claims and to prevent any fraud.

None of this data will be used for commercial or advertising purposes. The processing of data for marketing purposes shall always be subject to the agreement of the person concerned, who retains the right of withdrawal.

Foyer Santé is responsible for such processing. It may communicate such data to third parties in compliance with the terms and conditions stipulated in Article 300 of the amended law of 7 December 2015 on the insurance industry and relating to professional secrecy in insurance matters. Data protection is guaranteed with regard to third parties. Data transfers to third parties outside the EEA can only take place under the legal and regulatory obligations. Data may also be transferred to reinsurers, lawyers or other service providers as part of managing the insurance policy or its pre-contractual measures.

The Policyholder and the insured parties have the right to access their data and have amendments made. To do so, they should address a written request to the data controller.

The retention period for this data is limited to the term of the insurance policy and the period during which the retention of data is necessary for Foyer Santé to comply with its obligations regarding limitation periods and other legal obligations.

Foyer Santé processes the special categories of personal data relating to health for health service management purposes in accordance with national legislation on the protection of natural persons with regard to the processing of personal data and on the free movement of such data. If this data is processed for other purposes, your prior and explicit consent will always be required except in the case of a legal exception, such as the preservation of vital interests or the safeguarding of a legitimate interest.

Foyer Santé S.A. has designated a Data Protection Officer who may be contacted by posted mail addressed to the data protection officer or by email sent to dataprotectionofficer@foyer.lu.

3. Glossary

Incapacity to work	The *insured party* is temporarily unable to undertake his or her usual professional activity or any other gainful activity. The *incapacity to work* must be reported by a *medical authority*.
Medication	Any substance or composition with curative properties relating to a *disease*.
Medical Authority	A person authorised to practice medicine thanks to his or her medical degree. He or she can make a diagnosis related to the *disease* and/or a *bodily injury*.
Start of treatment	The *start of treatment* begins as soon as the need for treatment subsequent to a deterioration of the state of health or an accident has been reported.
Health facility	Any health care facility, whether public or private, permanently staffed by doctors, who follow medical records, and which is intended for people whose state of health requires a stay in the facility, as well as treatment and/or a diagnosis that requires observation, monitoring and continuity of care that can only take place in the facility. The following are not considered *health facilities*: closed psychiatric facilities, medical teaching facilities, nursing homes, approved nursing and care facilities, treatment facilities and sanatoria (convalescent centres).
Disease	The deterioration of the state of physical or mental health, the origin and symptoms of which could be determined and objectively ascertained by a *medical authority* to thereby diagnose and administer a necessary treatment; this deterioration must not, however, be due to a *bodily injury*.
Benefit	The reimbursement of health care costs and/or the payment of the daily benefits of the *insured party* subsequent to a *claim* covered by this policy.
Bodily injury	A sudden event beyond the control of the *insured party*, resulting in bodily harm, the cause of which is external to the victim's body and the symptoms can be determined and objectively ascertained by a *medical authority* to thereby diagnose and administer a necessary treatment.
Insurer	The term "*Insurer*" means Foyer Santé S.A. 12, rue Léon Laval, L-3375 Leudelange, the insurance company with which the policy is underwritten.
Insured party	The person named in the Special Terms and Conditions.
Claim	Mandatory medical treatment of an insured person following a *disease* or accident. The *claim* begins with the start of treatment and ends when a medical examination indicates that the treatment is no longer necessary. If the treatment must be extended for a *disease* or due to consequences of an accident not directly related to the current treatment, a new *claim* shall be made. With regard to the insurance for daily benefits, the *claim* must result in permanent incapacity to work. The *claim* shall conclude when *incapacity* to work and treatment are no longer necessary. If *incapacity to work* has been caused as a result of several *diseases* or accidents simultaneously, the daily benefits will be paid only once.
Policyholder	The person who enters into the insurance policy and who is required to make premium payments, and/or anyone replacing said person due to an agreement between the parties and/or the beneficiary loved ones of the *policyholder* upon said *policyholder's* death.