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global health

GENERAL CONDITIONS

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Policy documents

The mutual rights and obligations of the parties are governed by

- These General Conditions, which apply in common to all plans and the Special Conditions for each plan;
- The Definitions;
- The Particular Conditions and the medical appendices to the policy, which determine, in particular, the insured benefits and give an exact definition of the insured risk or risks.

The mutual rights and obligations of the parties derive from these policy conditions and any subsequent amendments.

1. Scope of Cover

The scope of cover and the individual cover limits are laid down in the General Conditions, the Special Conditions, the Particular Conditions (insurance policy) and their endorsements as well as the legal provisions of Luxembourg.

2. Policy Terms

2.1. Policy administration

2.1.1. Duty to declare when subscribing to a policy and during policy validity

2.1.1.1. When subscribing to a policy

The *policyholder* is obliged to answer all the insurer's questions truthfully and completely. The premium is set on this basis.

The policy will be null and void if the *insurer* is misled by intentionally omitted or inaccurate information relating to risk assessment. In such cases, the *insurer* has the right to retain any premiums already paid. The *insurer* has a recourse right for recovery of any amounts paid in settlement of claims, as well as for payment of all premiums due up to the date on which the *insurer* becomes aware of any omission or inaccuracy.

In the event of non-intentional omission or provision of false information, the *insurer* may, within one month from the date on which it becomes aware of this, propose an endorsement to the policy to take effect from that date.

If the *insurer*, however, proves that it would otherwise never have provided cover for the risk, then the *insurer* may cancel the policy within one month from the date it became aware of the breach of the duty to declare.

If the *policyholder* rejects the proposed amendment or if the proposal is not accepted after a period of one month from the date of receipt then the *insurer* may cancel the policy within two weeks.

In cases where the *policyholder* or the *insured* may be accused of non-fulfilment of the duty to declare and a claim occurs before the policy amendment or cancellation takes effect, then the *insurer* is only obliged to settle the claim pro rata to the amount of the premium actually paid and the premium that should have been paid if the risk had been correctly declared. If the *insurer* provides proof that the risk, whose true nature only came to light with the *claim*, would not otherwise have been insured then the *insurer*'s claim settlement shall be limited to a refund of the premiums or the premium instalments paid.

If several persons are covered by the insurance and the cancellation right for non-disclosure only relates to individual insured parties, then enforcement of the above rights may be limited to those individuals.

2.1.1.2. During policy validity

The *policyholder* or the *insured* person is obliged to disclose any change relating to the insurance policy that is likely to cause a significant and lasting increase in the risk insured.

2.1.1.3. More than one policy

If another health insurance policy exists in addition to this policy, then that other policy shall take precedence.

2.1.1.4. Right of withdrawal

If the contract is concluded via the *insurer*'s website the *policyholder* may withdraw from the contract within a delay of 14 calendar days without specifying a reason and without having to pay a fine.

The withdrawal period commences:
- On the day of the online completion,
- Or on the day that the *policyholder* receives the terms and conditions of the contract and information in case that point in time is later than the one aforementioned.

If the *policyholder* executes his right of withdrawal he informs the *insurer* before the end of the withdrawal period. The deadline is met if the information is sent before the expiry of the deadline in case where this information is in paper form (registered mail) or on another data carrier permanently accessible to the *insurer*.

2.1.2. Policy conclusion and effective date

Insurance cover takes effect on the date specified in the insurance policy, but not before completion of the insurance contract and not before the end of any waiting periods. The insurance contract shall be deemed to have been completed, as and when it has been signed by both contracting parties and the *policyholder* has paid the first premium or the first premium instalment.

No cover shall apply to claims that occurred before the insurance takes effect.

Medical expenses cover for new-born children begins immediately after the birth, without any waiting period and without risk assessment, provided that on the date of the birth of the child both parents have been *insured* with the *insurer* for medical expenses for at least three months and the request for insurance of the child is received not later than two months after the birth with retroactive effect to the first of the month in which the child was born. Insurance cover cannot be wider or more comprehensive

than that of the *insured* parents. New-born children may only be insured in insurance plans that are available for new policies.

2.1.3. Duration

The insurance policy begins on the date specified in the Particular Conditions (policy effective date). The insurance policy is valid for one year and is renewed on a tacit renewal basis for another period of one year unless cancellation notice has been served in time.

2.1.4. Premiums

2.1.4.1. Payment of premiums

Unless otherwise agreed, the legally permissible premiums, policy charges and taxes are payable in advance at the *insurer*'s registered office or at the offices of their duly authorised representative. Payment of premiums is an obligation falling on the *policyholder*.

If the policy covers more than one risk then the total premium is deemed to be one single amount.

The premium is an annual premium. It runs from inception of cover and is due at the beginning of each year of insurance. Other methods of payment are subject to the approval of the insurer.

The first premium is payable not later than the date of policy issue.

For newborn babies who are insured from birth, premiums are calculated as from the date of birth of the child.

2.1.4.2. Consequences of non-payment

In the event of non-payment of premiums or premium instalments, for whatever reason, within ten days after the due date, cover under the policy shall be suspended after a period of at least 30 days from the date of dispatch of a registered letter to the *policyholder* at his/her last known address. To ensure compliance with its duty to inform the *insurer* will also send the letter to the last known e-mail address. The registered letter contains the *insurer*'s demand for payment of the premiums due; it also stipulates the due date and the total amount of the premiums, as well as the consequences of non-payment on expiry of the period referred to above.

No notification of claim can be made on the *insurer* for any loss occurring during the time cover has been suspended.

The *insurer* has the right to cancel the policy ten days after the above-mentioned 30 day period.

If the policy has not been cancelled then cover shall resume at zero hour on the day following the date on which the *insurer* or its designated representative are paid the premiums due, or the instalments (if the annual premium is paid in instalments) that were the subject of the payment demand, as well as any premiums that had become due during the period of suspended cover and any legal or recovery costs.

Suspension of cover does not affect the rights of the *insurer* to lays claim to premiums that become due later, provided that the policyholder has been duly requested to pay. This right is, however, limited to two consecutive years' premiums.
Any policy that has remained suspended for non-payment of premium for an uninterrupted period of two years shall be cancelled automatically.

2.1.4.3. Modification of tariff or conditions

If the *insurer* intends modifying the terms and conditions of insurance and/or its tariffs, it can only do so in compliance with the provisions of the Insurance Contract Law* of 27 July 1997 and any subsequent amendments.

In certain cases, if the *insured* person reaches a certain age (for example transition from childhood to adulthood), the premium increases from the beginning of the calendar year, shall be that which corresponds to the higher age group. In this case the *insurer* is not obliged to inform the *insured* based on the provisions of the Insurance Contract Law* of 27 July 1997 and any subsequent amendments.

(**"Loi modifiee du 27 juillet 1997 sur le contrat d'assurance"*).

2.1.5. Benefits

2.1.5.1. Waiting periods

At the time of inception, there are waiting periods during which insurance cover shall only apply in the event of accident.

The waiting period for pregnancy (including any associated complications), childbirth, psychiatric services, psychotherapy and comprehensive dental care is ten months. The waiting period for fertility treatment is 24 months for both spouses or partners.

In the event of modification of the policy cover, these waiting periods shall apply to the newly applicable covers.

2.1.5.2. Declaration

The *policyholder* and/or the *insured* person(s) must declare any claim to the *insurer* as soon as possible and in any case within three years from the occurrence. If this is not possible due to unforeseen circumstances or "force majeure" then the *insurer* must be notified as soon as reasonably possible thereafter.

2.1.5.3. Obligations and formalities to be observed in the event of a claim

The *insured* has to take all necessary action without delay, in order to avoid a claim or to reduce the consequences of a claim.

The *policyholder* and/or the *insured* person(s) must immediately give the *insurer* all relevant information and answer all questions addressed to them, in order to determine the circumstances of the claim and make an assessment of its extent.

If the *policyholder* and/or the *insured* person(s) do not meet one of these obligations and this results in a loss for the *insurer*, then the *insurer* shall be entitled to reduce the claim settlement by the amount of the loss it has suffered. The *insurer* may refuse cover, if the *policyholder* and/or the *insured* person have wilfully not fulfilled their obligations.

For medical expenses cover, any hospital treatment must be notified within ten days of the start of such treatment. In the event of a breach of obligations the *insurer* may reduce the insurance benefits pro-rata to the loss it has suffered. The *insurer* may deny cover in the event of a wilful breach of obligations.

The requested information may also be provided to an authorised representative of the *insurer*. At the request of the *insurer*, the *insured* is obliged to submit to an examination by a doctor designated by the *insurer*.

2.1.5.4. Payment of benefits by the *insurer*

If benefits can also be claimed from a statutory health insurance fund, statutory or private personal accident insurance, statutory pension insurance fund or any other provider of benefits or institution, the *insured person* is obliged to assign all such rights to us.

The *insurer* is only liable to pay an insurance benefit when the voucher copy requested by it has been provided. This voucher copy becomes the property of the *insurer*.

The *insurer* reserves the right to store such evidence (voucher copy). When submitting cost records these must be the original documents, and must comply with the respective laws of the country which had issued the bill. In order to facilitate settlement and reimburse expenses as quickly as possible, the *insurer* will also accept cost records submitted by e-mail or fax, provided the quality of such evidence is acceptable. In case of legitimate interest, the *insurer* may request original supporting documents. If another health insurer or any other institution has participated in those expenses then copies of the supporting documents bearing their original stamp and acknowledgement of reimbursement will suffice. The insurer can also, with liberating effect, make a payment to the bearer or sender of proper original voucher copy.

Invoices must show: first name and surname, as well as the date of birth of the *insured* person(s), the doctor's exact description of the condition (diagnosis) or otherwise a precise description of the symptoms or coding under ICD-9 or 10 (International Classification of Diseases) plus each of the services provided with treatment date and itemised costs. For dental treatment a description of the teeth treated or replaced and the services provided must be given.

The prescription must show: first name and surname, as well as the date of birth of the *insured* person(s), the prescribed medication, the price and stamp attesting payment. Prescriptions must be submitted together with the associated medical bill or invoice for treatment or therapeutic aids or appliances.

In the case of not claiming a reimbursement, but the insured claims a flat daily hospital charge, then a certificate must be submitted confirming inpatient treatment, which clearly states the first and last name, as well as the date of birth of the person(s) treated, as well as a description of the medical condition, the date of admission and discharge and any days when the patient has been allowed to leave hospital.

The *insurer* has a right to insist that such voucher copy be provided on its own forms. These forms are to be completed by the *insured* and the doctor.

The *insurer* is entitled to pay out the benefits to the person who duly hands over or sends in the supporting documents. If there is a legitimate doubt as to the legality of this person, the *insurer* shall pay the amount of the refund to the *policyholder*.

Medical expenses in foreign currency are converted to Euros at the exchange rate on the day the supporting documents are provided to the *insurer*.

To ensure the processing of the documents can be done as quickly as possible (such as medical reports, invoices, and prescriptions), the *insurer* would ask the *policyholder/ insured* persons to provide

these in one of the following languages: French, German or English. In addition, the *insurer* recommends adding the supplement “Claims Form”.

Claims for insurance benefits can neither be assigned nor pledged.

2.1.5.5. Subrogation

Except where otherwise agreed, the *insurer* shall be subrogated to the rights and remedies of the *insured* up to the amount of the claims settlement paid.

If due to behaviour of the *insured* subrogation can no longer operate in favour of the *insurer* then the *insurer* can request refund of the compensation paid up to the amount of the loss sustained thereby.

An *insured* who has only received partial compensation may not be prejudiced by subrogation. In such cases the *insured* can assert a priority right against the *insurer* for payment of the remaining compensation.
Except in the case of malicious intent, the *insurer* has no recourse against the *insured*'s descendants, ancestors, spouse or relations by marriage in direct lineage nor against anyone living or a guest in his/her house nor against the *insured*'s domestic servants. However, the *insurer* may take recourse against these persons in so far as they have liability insurance under a valid policy.

2.1.5.6. Limitation of actions

The period of limitation for each claim on the insurance policy is three years. The period shall start to run from the date of the occurrence giving rise to the claim. If the person who is entitled to subrogation only becomes aware of this at a later date, then the limitation period shall start to run from that date only, but without exceeding five years from the date of the event, except in the case of malicious intent. The period of limitation shall not run against anyone who is unable to act in time due to "force majeure".

If the *insurance claim* is notified in due time, then the period of limitation shall be interrupted until the date on which the *insurer* announces its decision in writing to the other party. For the beneficiary of a claim, the period of limitation runs from the date on which he/she becomes aware both of the existence of the policy, their capacity as beneficiary as well as of the occurrence of the event giving rise to liability to pay the insurance benefits.

2.1.6. Termination

After the date of termination no benefits are payable, even for claim events that have already occurred and/or have already been notified.

2.2. Cancellation

2.2.1. Automatic cancellation

Any policy that has remained suspended for non-payment of premium for an uninterrupted period of two years shall be cancelled automatically.

In addition, cover shall end for any *insured* person who ceases to meet the insurability conditions set out in the tariff.

Policy cover shall cease on death of the *policyholder*. Nevertheless the *insured* persons have the right to continuity of cover by designating a new *policyholder*, provided this is done within two months of the death of the *policyholder*.

In cases of a granted divorce, the spouses are entitled to continue to enjoy policy cover as individual insured parties. The same applies to separated spouses.

2.2.2. Optional cancellation

If there are several cover items or insured risks then cancellation may apply either to the whole policy or to one or more cover items or risks.

2.2.2.1. Cancellation by the *policyholder*

The *policyholder* is entitled to cancel the insurance in total or for individual insured parties at the end of each policy year, but no sooner than the end of the agreed policy period. Cancellation notice must be sent no later than 30 days before the annual premium due date or else 30 days before the anniversary date of the effective date of the contract. The *policyholder* also has the right to cancel for a period of 30 days from the date of dispatch of the maturity notice by the insurer. Termination shall take effect on the second business day after serving cancellation notice, but at the earliest on the policy renewal date.

In the event of changes to the General Conditions the *policyholder is* entitled to cancel the insurance for the *insured* concerned within one month of receipt of notification of the changes. Cancellation shall take effect from the effective date of those changes.

If the premium is increased, then the *policyholder is* entitled to cancel the insurance for the *insured* concerned within 60 days from the date of dispatch of the maturity notice by the insurer. Termination shall take effect on the second business day after serving cancellation notice, but at the earliest on the policy renewal date.

If the *insurer* cancels cover under one or more of the *policyholder*'s policies or cancels another of the *policyholder*'s policies then the policyholder is entitled to cancel all his/her policies. Cancellation notice must be served within two weeks after the date of receipt of the *insurer's* declaration and will take effect at the end of the month in which such declaration is received.

If the *policyholde*r cancels policy cover in total or for individual insured parties then those insured parties have the right to continuity of cover by designating a new policyholder. Communication of this must be made within two months after the termination date. Cancellation shall only take effect when the *policyholder* provides evidence that the insured person(s) concerned are aware that cover is being cancelled.

2.2.2.2. Cancellation by the insurer

If one and the same benefit is wilfully insured under one or several insurance policies with too high a premium, then the policy is null and void. In this case, the *insurer* is entitled to retain the obtained premiums.

The *insurer* is entitled to terminate the insurance with immediate effect, if the policyholder, or an insured person fraudulently obtains or attempts to obtain an insurance benefit. The right to cancel comes to an end if it is not exercised within one month after the date on which the *insurer* has taken notice of the facts giving rise to the right to cancel.

If several person(s) are covered by the insurance and the cancellation right only relates to individual insured parties, then enforcement of the above rights may be limited to those individuals.

2.2.2.4. Bankruptcy of the policyholder

In the event of bankruptcy of the policyholder, insurance cover shall still apply to the general body of creditors who shall then be liable to the *insurer* for payment of any premium due after the declaration of bankruptcy. Nevertheless, the *insurer* and the curator are entitled to cancel the policy. The *insurer* may only cancel at least three months after the declaration of bankruptcy and such notice must be served within one month after expiry of that period. The curator may only cancel within the three months after the declaration of bankruptcy.

2.2.3. Cancellation notice

Cancellation notice may either be sent by registered mail or served by a bailiff or by handing over a cancellation letter against a receipt.

2.2.4. Refund of premium in the event of cancellation

Regardless of the grounds for termination, the premium relating to the period after the effective date of cancellation shall be refunded within 30 days of the effective date of termination. After expiry of this period the amount shall, as of right, attract interest at the statutory rate.

2.2.5. End of the Insurance

Insurance cover ends - even for outstanding claims - with termination of the insurance relationship.

In the interest of all involved parties the insurer complies with international regulation. The *insurer* is not obliged to provide insurance cover or to cover claims or other benefits under this insurance contract, if the benefits of such an insurance cover, the payment of such claims or the provision of such benefit will expose the *insurer* to a sanction, a ban or a limitation under a resolution of the United Nations, under commercial or economic sanctions, under laws or provisions of the European Union or of the United States of America.

2.3. Miscellaneous

2.3.1. Several policyholders

In the case of several *policyholders* these shall be jointly and severally liable for policy obligations.

In the event of partial cancellation or any other reduction of insurance cover then the provisions of the foregoing paragraph shall apply only for this reduction and in accordance with that which is stipulated.

The *policyholder,* acting both in his/her own name and in the name and for the account of other insured parties, hereby allows the *insurer* to process medical or sensitive data, relating both to him/her and to other insured parties, to the extent this is necessary for the purpose of this insurance policy.

2.3.2. Notifications

All *insurer* notifications to the *policyholder* may validly be addressed to his/her last known place of residence. In cases where there are several *policyholders* then each notification of the insurer to any one of them shall be legally binding on all of them. All notifications to the *insurer* must be sent to the *insurer*'s registered office.

2.3.3. Complains

In any dispute related to the insurance policy, the *policyholder* may address a written complaint

- either to the insurer's general management;
- or to the Insurance Ombudsman (c/o: Association des Compagnies d'Assurances, 12, rue Erasme, B.P. 448, L-2014 Luxembourg, or to the Luxembourg consumer association: Union Luxembourgeoise des Consommateurs: 55, rue des Bruyères, L-1274 Howald);
- or to the Insurance Supervisory Authority: Commissariat aux Assurances (7, Boulevard Joseph II, L-1840 Luxembourg),

without prejudice to the policyholder's right to take legal action.

2.3.4. Applicable law and place of jurisdiction

The policy is governed by Luxembourg law. For any dispute arising from the insurance policy, solely the courts of the Grand Duchy of Luxembourg shall have jurisdiction, without prejudice to the application of international treaties or agreements.

2.3.5. Local laws

In certain countries insurance cover is subject to local laws for health insurance providers, especially for local residents. The *policyholder* and the *insured* person(s) are responsible for making sure that their health insurance corresponds to the legal requirements. The insurance cover provided by Foyer Santé is not a substitute for a national statutory health insurance.

3. Insurability

Insurable are all persons who temporarily reside abroad for at least 3 months.

Excluded from insurance cover are all persons who permanently reside in the USA.

If the *insured* person respectively his/ her co-insured persons permanently take(s) up residence in the USA the insurer will terminate the insurance relationship. For any changes of place of residence in all other countries the insurer may review while the insurance relationship is ongoing if the insurance relationship is conform to the local laws. According to the outcome of this review the insurer may decide whether the insurance cover can continue to be granted or if it has to be modified or terminated.

4. Definitions

Incapacity to work	The *insured person* is temporarily and absolutely incapable of undertaking his/her usual professional activities or other gainful activity. *Incapacity for work* must be attested by a medical *authority*.
Medication	Any substance or compilation that has healing properties in terms of a disease.
Medical authority	A person, who is authorised to practice medicine by virtue of having graduated from Medical School. This person is entitled to pronounce a diagnosis of a disease and/or bodily injury following an accident.
Start of treatment	*Treatment* begins with the determination of the need for care as a result of a deterioration of health, or an accident.
Hospital	Any public or private healthcare institution, which is constantly under medical supervision, keeps medical records, and is intended for use by persons whose state of health requires a stay in the institution for continuous medical treatment and/or diagnosis, observation or monitoring that only the institution can provide. The following are not deemed to be hospitals: closed psychiatric institutions, medical teaching facilities, convalescent homes, approved recreation and nursing homes, spas and sanatoriums.
Disease	A deterioration of physical or mental health, for which the cause and symptoms can be objectively identified therefore making diagnosis possible and treatment a necessity. Such deterioration may not be due to an accident causing bodily injury.
Benefit	Reimbursement of medical expenses or payment of daily benefits to the insured following a claim admissible under the policy.
Accident involving personal injury	A sudden event, occurring against the will of the *insured*, which causes bodily injury for which the cause and symptoms lie outside the victim's body and can be objectively identified therefore making diagnosis possible and treatment a necessity.
Insurer	The term "insurer" shall mean Foyer Santé S.A. 12, rue Léon Laval L−3372 Leudelange, being the insurance company issuing this policy.
Insured	The person(s) named in the insurance policy.
Claim	The medically necessary treatment of an insured person, as a result of illness or accident. A claim begins with the *treatment*; it ends after a medical examination confirms treatment is no longer required. If the treatment has to be extended to a disease or the consequences of an accident, not in direct connection with the ongoing treatment, then this is deemed to be a new claim. As regards daily benefits, the claim must involve permanent *incapacity for work*. The claim ends when *incapacity for work no longer applies and* the treatment is no longer required. If incapacity for work is caused by several illnesses or accidents, daily benefits will only be paid once.
Policyholder	The person who concludes the insurance policy and is responsible for premium payment, or else any person who as a result of an agreement between the parties acts on their behalf, or the dependants of the *policyholder* on his/her death.