



# **Deluxe International**

General Terms and  
Conditions of Medical  
Expenses Insurance and  
(Daily) Hospital Benefit  
Insurance

Version: 1.9.2008

# List of contents

page

## **Deluxe International**

**General Terms and Conditions of  
Medical Expenses Insurance an (Daily) Hospital Benefits Insurance**

**General provisions**

3

**IDLA Tariff            Medical Expenses Insurance in foreign countries**

6

**The General Terms and Conditions in English are just a translation, and the German General Terms and Conditions represented the legal documents.**

### **Interlux**

Assurances Maladie Société Anonyme

10 B, z. a. Bourmicht  
L-8070 Bertrange  
LUXEMBOURG

Tél.: (00352) 290 090  
Fax: (00352) 290 095  
E-mail: [interlux@interlux.lu](mailto:interlux@interlux.lu)  
Internet: [www.interlux.lu](http://www.interlux.lu)  
R.C. Luxembourg B 84514

#### The Insurance Cover

##### § 1 Purpose, Scope and Validity of the Insurance Cover

- 1) The insurer offers insurance cover for sickness, accidents and other events specified in the contract. On occurrence of the insured event it provides
  - a) refund of expenditure for curative treatment and other agreed benefits under the medical expenses insurance
  - b) a daily hospital allowance in the event of in-patient treatment under the hospital benefit insurance.
- 2) An accident occurs if the insured involuntarily suffers damage to his health through a sudden, external event having an effect on his body (accident occurrence).

If a joint is dislocated or muscles, tendons, ligaments or articular capsules are strained or torn by increased exertion on limbs or the spinal column, this is also considered to be an accident.
- 3) The insured event is the medically necessary curative treatment of an insured person for illness or the consequences of an accident. The insured event begins with the curative treatment; it ends when no further treatment is required according to medical findings. If the curative treatment has to be extended to an illness or the consequence of an accident which is not causally connected with that hitherto being treated, a new insured event arises in this respect. Examination and treatment which is medically necessary in connection with pregnancy and delivery are also considered to be an insured event.
- 4) The extent of the insurance cover is shown in the insurance certificate, subsequent written agreements in writing, the General Terms and Conditions of Insurance (including tariff with tariff conditions) and the statutory provisions in Luxembourg.
- 5) The insurance protection covers curative treatment only in foreign countries. "Home" is considered to cover all countries of which the insured person holds nationality and the country in which they have their permanent residence. If a stay abroad is temporarily interrupted, then within the agreed contractual term (including any additional insurance, cf. Part II, number 2) – even in the case of multiple interruptions – insurance cover will continue to exist at home for a total period of up to six months.

##### § 2 Commencement of Insurance Cover

- 1) The insurance cover commences at the time indicated in the insurance certificate (commencement of insurance), **but not before the conclusion of the insurance contract** – that is to say, not before the insurance certificate has been signed by both contracting parties (facsimiles suffice). **No payment will be made** in respect of insured events which have occurred before the commencement of insurance cover. **Insured events taking place after conclusion of the insurance contract are only excluded from the payment obligation in respect of the part falling in the period before commencement of insurance.**
- 2) In the case of newborn babies insurance cover shall commence immediately after the birth, if on the date of birth one parent has been insured with the insurer for at least three months, and the application for insurance is made at the latest two months after the date of birth, with back-dated effect to the first day of the month of birth. The insurance cover may not be higher or more comprehensive than that of an insured parent. Insurance cover is also provided for birth injuries and congenital illnesses and disabilities under these conditions.

##### § 3 Waiting Periods

No waiting periods are provided.

##### § 4 Scope of the Payment Obligation

- 1) The type and amount of the insurance benefits are shown in the tariff with tariff conditions.
- 2) The insured person is free to choose between licensed practising doctors and dentists. The services of a non-medical practitioner in the Federal Republic of Germany as well as the drugs, surgical materials and remedies prescribed by him are also reimbursable. The services of non-medical practitioners cover all treatment performed by non-medical practitioners according to the list of fees for non-medical practitioners in the 1985 version issued by the associations of non-medical practitioners in the Federal Republic of Germany (GebüH).
- 3) Drugs, surgical materials, remedies and aids must be prescribed by the treating professionals listed in the first sentence of subsection 2, and drugs must be obtained from a pharmacy.

**Foods and tonics or substances which are taken habitually or as a preventive measure are not subject to the obligation to reimburse, even if they are medically prescribed. Disinfectants, as well as cosmetic substances, wines, mineral water, bath additives, etc, are not considered to be drugs.**

Physical-medical curative measures by members of state-recognised healing professions, i.e. inhalations, physiotherapy, exercise therapy, massages, hydrotherapy and packs, medicinal baths, heat treatment, electro-therapy, light therapy are considered to be remedies. **Additional expenditure for treatment in the patient's home is not refundable. Saunas, thermal baths and similar baths are excluded from refund.**

Spectacle lenses (a supplement may be paid for the frames), contact lenses, trusses, walking calipers, wheelchairs (up to an invoiced amount of EUR 2,500.00), walking supports, compression support stockings, corrective foot insoles/arch supports, orthopaedic footwear (up to an invoiced amount of EUR 500.00 per year) hearing aids, body replacement parts, speech aids, speaking devices (electronic larynx), support equipment including support surfaces are considered to be aids. Expenditure for the repair of aids, **except to soles and heels of customised orthopaedic shoes**, is reimbursable under the above rules. Benefits for necessary aids of a similar type will be granted once in a calendar year against proven requirement, unless a longer period of use or serviceability is assumed.

**Expenditure for all other aids, medical equipment and sanitary requisites (e.g. massage equipment, equipment for measuring blood pressure, inhalation devices, radiation lamps, heat pads) and for operational maintenance, use and care of aids is not reimbursable.**

- 4) In the event of in-patient curative treatment which is medically necessary, the insured person has a free choice between the public and private hospitals which are under permanent medical management, have adequate diagnostic and therapeutic facilities, work in accordance with generally recognised scientific methods and hold medical records.
- 5) **In the event of in-patient curative treatment which is medically necessary in clinics which also conduct health cures or sanatorium treatment or accept convalescents, but otherwise meet the requirements of subsection 4, the tariff benefits will only be**

granted if the insurer has agreed to them in writing before the commencement of treatment.

- 6) **In the event of out-patient and in-patient psychotherapy, payment will only be made if and insofar as the insurer has given an assurance in writing before the treatment on the basis of a report from a doctor commissioned by it.**
- 7) The payment year shall be the calendar year. In order to establish the calendar year to which curative treatment expenses are to be allocated, the treatment dates and/or the time of procurement of the drugs and aids shall apply.

## § 5 Restriction of the Payment Obligation

- 1) **There shall be no obligation to pay**
  - a) **for such illnesses, including the consequences thereof, and for consequences of accidents and for deaths which are caused by wartime events or recognised as military service injuries and which are not expressly included in the insurance cover;**
  - b) **for illnesses and accidents based on intent, including the consequences thereof, and for withdrawal measures, including withdrawal treatments. Measures for habit breaking and detoxification are also considered to be withdrawal treatments;**
  - c) **for treatment by doctors, dentists and in clinics whose invoices the insurer has excluded from reimbursement for an important reason, if the insured event occurs after the policy holder has been notified of the exclusion from benefit. If at the time of notification an insured event is pending, there shall be no obligation to pay for expenditure incurred more than three months after the notification;**
  - d) **for health cure and sanatorium treatment and for rehabilitation measures;**
  - e) **for out-patient curative treatment in a spa or health resort.** This restriction does not apply if the insured person has his permanent residence there or if during a temporary stay curative treatment becomes necessary for an illness unrelated to the reason for the stay or an accident which occurs there;
  - f) **for examination and treatment methods and drugs which are not generally scientifically recognised;**
  - g) **for treatment by spouses, parents or children.** Evidenced material costs will be reimbursed in accordance with tariff;
  - h) **for accommodation made necessary by care requirements or custody;**
  - i) **on account of measures which are not directly required to remedy conditions of illness, in particular cosmetic measures of any type and the consequences thereof;**
  - j) **for termination of pregnancy and sterilisation.**
- 2) **If a curative treatment or other measure for which payment is agreed exceeds that which is medically necessary, the insurer may reduce its payments to an appropriate amount.**
- 3) **If a claim also exists to benefits under statutory accident insurance or statutory pension insurance, to statutory curative care or accident care, the insurer shall only be liable to pay for expenditure which is still required notwithstanding the statutory benefits, irrespective of the claims of the policy holder to daily hospital benefit.**
- 4) **In the event of in-patient treatment of mental and psychiatric illnesses and partial in-patient treatment there is no right to benefit under hospital benefit insurance.**

## § 6 Payment of Insurance Benefits

- 1) The insurer is only obliged to pay if it is provided with the evidence it requests, which becomes the property of the insurer.

- 2) The cost vouchers must be presented in the original and must contain:
  - name of the person treated, designation of illness, statement of the individual services with the respective treatment dates. If the doctor providing treatment refuses to state the nature of the illness, the insurer is entitled to make its payments subject to a medical examination in accordance with § 9 subsection 3.
- 3) The amount of any payments made by another insurer or another paying authority must be confirmed by that party on the relevant vouchers.
- 4) If hospital benefit alone is being claimed, a certificate from the hospital or hospital doctor in respect of the in-patient treatment is to be submitted as evidence, containing the name of the person treated, the designation of the illness and the admission and discharge date.
- 5) The insurer is entitled to pay to the bearer or sender of proper evidence.
- 6) Medical expenses incurred in foreign currency are converted into euros at the rate ruling on the day on which the vouchers are received by the insurer. The current rate shall be considered as the official euro exchange rate of the European Central Bank. For non-traded currencies, in respect of which no benchmark rates have been set, the rate applying shall be based on the latest "Exchange Rate Statistics" of the European Central Bank, Luxembourg, unless the insured person is able to prove on the basis of banking documentation that they acquired the currency required for payment of invoices at a less favourable rate.
- 7) **Costs for the remittance of the insurance payments and for translations may be deducted from the payments.**
- 8) Claims to insurance payments may not be assigned or pledged.

## § 7 End of Insurance Cover

**The insurance cover shall end – even for insured events which have already occurred – upon termination of the insurance relationship.**

## Obligations of the policy holder

### § 8 Payment of Premiums, Calculation of Premiums

- 1) The policy holder must pay the agreed contribution (premium) and the incidental expenses including taxes.

The premium is set in accordance with the respective age and gender on commencement of insurance and on extension of the contract in respect of the agreed payment and on contractual amendments in respect of the agreed additional benefit. The age is calculated from the difference between the year of birth and the year of the commencement of insurance, of contractual extension and contractual amendment respectively.

In the case of extensions of contracts, the premium for the respective age and gender shall apply in accordance with new-business premiums.

For existing insurance relationships the premium increases according to the age scale provided in the tariffs, in each case as from the beginning of the calendar year in which the next age grade upwards is reached.
- 2) The premium is an annual premium and is calculated from the commencement of insurance. It is payable at the beginning of each insurance year, but may also be paid in the monthly premium instalments laid down in the tariff, which are considered in each instance to be deferred until the due date of the premium instalment. The premium instalments are due on the first of each month – even after occurrence of the insured event.
- 3) The first premium or the first premium instalment is payable immediately after delivery of the insurance certificate at the latest, but not before commencement of the insurance.

- 4) The premiums or the premium instalments are to be paid until the end of the month in which the insurance relationship ends; premiums paid beyond that date will be refunded. If the insurer is required to pay incidental costs beyond the end of the insurance relationship, these will be chargeable to the policy holder in full and will be due at the end of the insurance relationship at the latest.
- 5) The premiums are claimable at the domicile or place of residence of the policy holder.
- 6) If the premium has not been paid within a period of ten days after the due date, the insurer may demand payment from the policy holder at the end of this period. This payment demand is to be effected by a reminder in the form of a registered letter addressed to the last known domicile of the policy holder. The costs of the above-mentioned demand for payment are to be refunded with the premium payment and are payable by the policy holder under all circumstances.
- 7) **If payment of the premium or the costs referred to in subsection 6 is not made within thirty full days from receipt of the reminder, the insurer shall be released from payment for treatment cases arising after expiry of this time limit.**  
The payment obligation of the insurer is reinstated for all new treatment cases arising, if the policy holder has paid the premiums due up to this date and the proven costs of the collection procedure. **However there is no obligation to pay if the policy holder does not pay until a time at which the occurrence of the insured event is no longer uncertain.**
- 8) If the conditions referred to in the first sentence of subsection 7 exist, the insurer may terminate the contract within 10 days – apart from being released from payment.
- 9) The premiums are calculated using technical calculation principles.
- 10) In the event of changes in premiums the insurer may also change specially agreed premium supplements.

### § 9 Obligations

- 1) The policy holder shall, at the request of the insurer, provide any information and produce any items of proof which are necessary to establish the insured event or the payment obligation of the insurer and the scope thereof.
- 2) The policy holder is obliged to submit a treatment and cost schedule to the insurer before commencement of treatment in the event of tooth replacement, orthodontics and psychotherapy.
- 3) At the request of the insurer, the insured person is obliged to undergo an examination by a doctor appointed by the insurer.
- 4) Medical expenses insurance or hospital benefit insurance may only be concluded or increased with another insurer with the consent of the first insurer (Interlux).

### § 10 Consequences of Breach of Obligations

- 1) **The insurer shall be released from the obligation to pay benefit if one of the obligations referred to in § 9 subsections 1 to 3 is breached.** In the event of breach with gross negligence the insurer shall only remain liable to payment insofar as the breach has not had an effect either on the establishment of the insured event or on the establishment or the extent of the payments incumbent upon the insurer.
- 2) If the obligation referred to in § 9 subsection 4 is culpably breached, the insurer may terminate the contract with immediate effect within three months from the time at which it became aware of the breach. **In the event of termination the insurer is released from the payment obligation.**
- 3) The knowledge and the fault of the insured person are equal to the knowledge and fault of the policy holder.

### § 11 Claims on Third Parties

If the policy holder or an insured person has compensation claims of a non-insurance type against third parties, there is an obligation, irrespective of the statutory claim transfer, to assign these claims to the insurer in writing, up to the amount to which reimbursement of costs is effected under the insurance contract. **If the policy holder or an insured person gives up such a claim or a right serving as security for the claim without the consent of the insurer, the latter shall be released from the payment obligation insofar as it could have obtained compensation out of the claim or the right.**

### § 12 Offsetting

The policy holder may only offset against claims of the insurer insofar as the counter claim is established without dispute or with legally binding effect.

### § 13 Statute-barring

**Any claim arising from the contract shall lapse under the statute of limitations upon three years from the time of the event on which it is based.**

### § 14 Termination and Invalidity of the Insurance Relationship

- 1) The policy holder may in the cases set out at subsection 4 demand the cancellation of the insurance relationship in respect of the persons not affected within two weeks from receipt of the statement of the insurer at the end of the month in which the statement was received.
- 2) The insurer may terminate the insurance relationship without notice, if the policy holder or an insured person have fraudulently acquired insurance benefits or attempt to acquire insurance benefits in a fraudulent manner. The right to termination expires, if it is not exercised within one month from the time at which the insurer became aware of the facts giving rise to the right to termination.  
Other extraordinary rights of termination of the insurer remain unaffected. The ordinary right of termination of the insurer is excluded.
- 3) **The contract shall be void if, by culpable breach of the obligation to notify, the assessment of the risk is changed in such a way that the insurer would not have concluded the contract at all, or not on the same conditions, if it had been aware of the withheld circumstances. The same applies to breach of the obligation to notify in the case of contracts in respect of the revision or reinstatement of insurance cover.**  
**The policy holder is obliged to pay back insurance benefits received. The insurer must repay the premiums paid, unless the breach of the obligation to notify was deliberate.**
- 4) If, in the case of insurance relationships which cover several insured persons, the conditions for termination under subsection 2 or invalidity under subsection 3 exist with respect to individual insured persons only, the exercise of the above rights may be restricted to those persons.

### § 15 Other Grounds for Termination

- 1) The insurance relationship ends with the death of the policy holder. However, the insured persons have the right to continue the insurance relationship by the appointment of the future policy holder. The declaration is to be made within two months from the death of the policy holder.
- 2) In the event of the death of an insured person the insurance relationship with that party ends.
- 3) If the insured party returns permanently from abroad, the insurance cover shall end upon the expiry of the month in which return is notified, but at the latest six months following the return home. If just one person ends their stay abroad, then the insurance cover shall end accordingly.

If an insured person moves away the insurance relationship with that party ends.

## Other Provisions

### § 16 Declarations of Intention and Notifications.

- 1) Declarations of intention and notifications to the insurer must be made in writing. Insurance agents are not authorised to accept them. This does not apply to applications for the conclusion or amendment of health insurance contracts.
- 2) If the policy holder has not advised the insurer of a change of residence, it is sufficient for a declaration of intention made to the policy holder to be legally valid if it is sent to the last address known to the insurer. The declaration becomes effective at the time at which it would have reached the policy holder by normal post if there had been no change of address.

### § 17 Place of Jurisdiction

The courts of the Grand Duchy of Luxembourg shall be exclusively competent for all disputes arising from the contract between the policy holder and the insurer.

**The General Terms and Conditions of Insurance in English are just a translation, and the German General Terms and Conditions represented the legal documents.**

# Deluxe International

## Part II Medical Expenses Insurance IDLA Tariff

This tariff (Part II of the General Terms and Conditions of Insurance) is only valid in connection with Part I – General Provisions.

### 1. Persons covered

All persons under the age of 65 can be covered.

### 2. Period of insurance

The period of insurance is a maximum of one year. At the end of the agreed period of insurance the policy holder may apply for a one-off continuation insurance on the insurance conditions currently applying, provided that the other conditions continue to be met. Thereafter, the policy holder may twice apply for a one year continuation of the insurance, provided that the other conditions continue to be met. If the application for continuation insurance is submitted by the end of the originally agreed period of insurance, the continuation insurance is provided without another risk assessment, directly following on from the original insurance contract. Current insured events are then included in the new insurance cover.

If the return journey by the end of the agreed period is not possible without endangering the health of the insured person (i.e. they are unfit to travel), then the insurance cover shall be extended on a one-off basis by two months.

### 3. Benefits from the insurer

Reimbursable expenditure is refunded in accordance with the percentages stated below.

#### A. Out-patient curative treatment

The tariff benefit is 100% of the reimbursable expenditure for:

- medical services
- drugs and surgical materials
- remedies
- aids

The cost of transportation required for medical reasons in the country of stay using a special ambulance to and from the nearest doctor or hospital deemed suitable according to medical criteria shall be reimbursed.

In the event of the death of the insured person abroad the expenditure for the funeral at the place of death or transfer to the deceased's last permanent place of residence are refunded up to a total amount of EUR 10,000.

The services of a non-medical practitioner in the Federal Republic of Germany and drugs, surgical materials and remedies prescribed by him are refunded up to a limit of 80% (up to EUR 400) per year.

#### B. Dental Treatment

The tariff benefit for

- |   |      |
|---|------|
| – dental treatment will be  | 100% |
| – tooth replacement (dentist's fees, material costs and lab fees) including repairs, crowns and orthodontics, will be | 80%  |
- of the reimbursable expenditure.

For tooth replacement and dental crowns the following costs are reimbursable to a maximum of:

#### Fixed dentures

Crowns	546 EUR
Inlay, gold	496 EUR
Simple post crown	422 EUR
Richmond post crown	744 EUR
Post crown tooth with synthetic structure	744 EUR
Bridge unit, gold and synthetic material	496 EUR
Bridge unit, gold and ceramic	546 EUR
Special retainers	546 EUR
Abutments	199 EUR

Implants (synthetic root and crown structure) including preparatory work and measures 744 EUR

#### Removable dentures

Full set of dentures, upper or lower (14 teeth, synthetic plate) 1,029 EUR  
 Partial denture (synthetic plate)  
 – Lower plate 229 EUR  
 – per tooth 72 EUR  
 – per clasp 53 EUR  
 Completed with steel (per arch) 261 EUR  
 Supplemented by suction system (Lausap, Fixomatic, Vacuum, etc) 261 EUR  
 Denture framework, cobalt-chrome  
 – on a clasp basis 633 EUR  
 – per tooth 211 EUR

#### C. In-patient curative treatment

The tariff benefit is 100% of the reimbursable expenditure for:

- medical services,
- accommodation in a single room (1st class)
- diagnostic, therapeutic and other related services, invoiced separately by the hospital (for example, laboratory or X ray investigations, drugs, use of operating theatre),
- The cost of transportation required for medical reasons in the country of stay using a special ambulance to and from the nearest hospital deemed suitable according to medical criteria shall be reimbursed.

The additional costs of a return journey from abroad required for medical reasons and ordered by a medical practitioner shall be borne if adequate medical treatment cannot be assured in situ or at a reasonable distance and there is therefore a risk of endangerment to health; moreover, the additional costs for one accompanying person shall be reimbursed if this is medically necessary and a medical practitioner has given instructions to that effect. Return transportation shall be to the nearest hospital at home deemed suitable according to medical criteria (cf. Part I, Section 1 para. 5).

In the event of the death of the insured person abroad the expenditure for the funeral at the place of death or transfer to the deceased's last permanent place of residence are refunded up to a total amount of EUR 10,000.

**There is no payment obligation for implants (synthetic root and crown construction) including preparatory work and measures.**

#### Payment of (Daily) Hospital Benefit

If no costs are drawn in full in-patient treatment, a daily hospital benefit of 25 EUR is payable. Under the same circumstances the daily hospital benefit for children (0-15 years) is EUR 12.50. **Patients undergoing partial in-patient treatment (semi-admittance) have no entitlement to hospital benefit.**

#### D. Assistance benefits

Accommodation of a parent in a child's hospital room

If the child has to stay in hospital, Interlux will bear the costs for the accommodation of one parent staying in the child's room overnight (children up to 12 years).

#### 4. Payments by the policy holder

Monthly premiums result from the insurance policy and the tariffication table listed below. Statutory insurance tax is not included in the premiums and will be levied separately.

<b>Premiums of the Tariff IDLA</b>		
Monthly premium installments in EUR per person		
Age	Male insured	Female insured
0 – 15 years	187,34	187,34
16 – 20 years	194,09	279,14
21 – 25 years	211,42	336,98
26 – 30 years	225,62	343,06
31 – 35 years	244,34	350,21
36 – 40 years	274,54	357,72
41 – 45 years	312,59	368,08
46 – 50 years	346,39	425,33
51 – 55 years	387,76	440,36
56 – 60 years	425,81	453,36
61 – 65 years	809,95	838,87

