Practical guide

Brochure for patients

Fondation Cancer
Info · Aide · Recherche

cancer.lu

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in German, French and Portuguese.

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Whenever the masculine gender is used, it shall be deemed to include the feminine.

In the online version of this brochure, any underlined text indicates a link that you can click for more information or to go directly to the source.

Preface

Dear readers,

Welcome to this practical guide. This brochure was produced with just one goal in mind: to give you clear, practical answers to any questions you may have during your fight against cancer.

We understand that this is a worrying time, which brings with it a great deal of organisational challenges on both a personal and a professional level. Therefore, in this brochure we have assembled useful information on the benefits provided by health insurance schemes, healthcare services, employment law and financial support.

Please don't hesitate to get in touch if you have any questions. We are here to help you every step of the way.

The Cancer Foundation (Fondation Cancer) team

Contents

I. Healthcare

If you live and/or work in the Grand Duchy of Luxembourg, you should be affiliated to the CCSS (Public Social Security Centre) as the main insured person or an additional insured person (family member of the main insured person). As a result, you can access a range of social security services in Luxembourg (health insurance, pension insurance fund, family benefits, etc.) and you are entitled to healthcare services through a public or private healthcare insurance fund depending on the main insured person's employer. Persons in receipt of specific benefits (e.g. sick leave cash allowance, unemployment benefits, etc.) as well as students, who have obligatory or optional insurance with the CCSS, can also receive obligatory healthcare insurance benefits.

Since 2009, the following healthcare funds have been in place in Luxembourg:

- a **private sector healthcare fund**, known as the (CNS) (the national healthcare fund/*Caisse nationale de santé/ Gesondheetskeess*)
- three **public sector healthcare funds**, namely:
  - » the CMFEP (Healthcare fund for civil servants and public employees);
  - » the CMFEC (Healthcare fund for civil servants and municipal employees);
  - » the EM-CFL (Mutual healthcare assistance of the national railway company of Luxembourg).

The private sector healthcare fund (CNS) contributes to the healthcare expenses of its insured members in accordance with its statutes.

The healthcare funds of insured persons in the public sector (CMFEP, CMFEC and EM-CFL) apply the statutes of the CNS to work out their contribution to healthcare expenses.

NB: In the interests of clarity, we will use the term CNS in subsequent explanations and procedures. Persons insured by other healthcare funds should refer to their healthcare insurance provider for information on procedures (e.g. making a claim, healthcare records, etc.)

Information and contacts

See part V. Useful addresses p. 68

Oncology services at hospitals in Luxembourg

All hospitals in Luxembourg have an oncology department. Please see below for a list of doctors in these departments, who treat patients affected by cancer.

Emile Mayrisch Hospital
Centre Hospitalier Emile Mayrisch
Esch/Alzette

Luxembourg City Hospital
Centre Hospitalier Luxemburg
Luxemburg-Ville

The breast cancer clinic received the *OnkoZert* certification from the German cancer society *(DKG)* for centres of excellence for breast cancer.

Robert Schuman Hospitals
Hôpitaux Robert Schuman Luxembourg-Ville **(Zitha & Kirchberg)**

The *Prostatakarzinomzentrum* at the HRS received the *OnkoZert* certification from the German cancer society *(DKG)* for centres of excellence for prostate cancer.

Nord Ettelbruck Hospital
Centre Hospitalier du Nord Ettelbruck

National Radiotherapy Centre François Baclesse
Centre François Baclesse Esch/Alzette
(=Centre National de Radiothérapie)

Obviously, other specialists will be involved in your treatment depending on your type of cancer, including surgeons, gynaecologists, urologists, gastroenterologists, etc.

Useful info

To take part in ongoing clinical trials as a patient, you should refer to the table published by the CNER (National Research Ethics Committee/*Comité National d'Ethique de Recherche*). Please note that the trials addressed in the table also include illnesses other than cancer.

Information and contacts

CNER
T 247-65650 / 247-65651 / 247-55518
E contact@cner.lu

The referring doctor

Your cancer treatment is a very complex process. You will need to go through a series of medical examinations and procedures. You will be treated by oncologists, radiotherapists, anatomical pathologists, other specialists, and other health and social care providers. Your treatment requires close coordination of the procedures carried out and the information exchanged between those involved in your care and you.

You can be assisted by a **referring doctor** during your treatment. The referring doctor will coordinate your treatment and play a key role in monitoring how your health is progressing. In the event of complex illnesses and treatments, a number of different specialists will be involved, which some patients can find disconcerting.

The referring doctor will support you, advise you and guide you throughout your treatment.

Who can be my referring doctor?

It is up to you to choose your referring doctor. It must be a general practitioner who provides primary care outside of hospitals.

This should be the doctor who is the most easily accessible for you and who is your first choice for consultation. (Remember that the doctor does not have to agree to be your referring doctor, they have the right to refuse).

You both sign a referring doctor declaration. The referring doctor shall complete the declaration with you and send it to the CNS. A reference number is created and you will be registered on the referring doctor system.

Can I withdraw the referring doctor declaration?

The connection between the referring doctor and the patient is established for an unlimited duration. However, you may withdraw the declaration to the CNS at any time.

Information and contacts

CNS – Referring doctor service
Service médecin référent
T 27 57-46 50
F 27 57-46 00
E via a contact form

Shared Care Record (DSP)

The DSP (shared care record/*dossier de soins partagé*) is crucial for coordinating several different medical specialists. The goal is to ensure optimal medical care that takes your state of health into account.

What is a DSP and what is it for?

A DSP is created by *Agence eSanté* for every patient. You can therefore activate and use a DSP, even if you choose not to use the referring doctor system, to give access to the various doctors treating you so that they can add information to it.

The DSP is your personal digital medical record, which contains information about your health, illness and treatment. The DSP is secured with a password system.

You, your referring doctor and your specialists (to whom you have decided to grant or deny access) can exchange information and coordinate your medical care.

When you use the DSP as part of the referring doctor system, the referring doctor will provide a patient summary (no later than three months after the referring doctor declaration is signed).

The CNS adds a summary of all services provided and examinations conducted. As a result, the DSP offers an overview of your health information and your treatment. The patient summary is regularly updated by the referring doctor.

How is my information kept secure?

Your information is stored in a virtual safe deposit box located in Luxembourg. The information is sent securely and is stored in encrypted format. To read, retrieve or send information about the patient, a highly secure user identification is required (via a unique password similar to the system for accessing bank accounts). In addition, the healthcare professional in question must be on the national register of healthcare professionals.

It is up to you, the patient, whether you wish to grant other users access to your DSP.

Information and contacts

Helpdesk Agence eSanté
T 27 12 50 18 33
E helpdesk@esante.lu

Care and assistance at home

Domestic care services are organised by various bodies such as family assistance services and some local authorities, which can send people to your home to do day-to-day jobs for you while you are unwell. Contact the service of your choice or the social assistance service in your local area, which will be able to give you information on services and/or assistance available.

I need housekeeping assistance and/or assistance with childcare. Who should I contact?

Traditional family assistance

The Family assistance service provides practical help for your family. This is intended for families/people under 65 in the event of illness, disability or other social factors and provides short-term or limited duration help around the home and assistance with childcare.

By producing a medical prescription demonstrating that you need help around the home due to your illness or treatment, you can benefit from a subsidised rate adjusted depending on your income.

If you are unable to pay these costs, get in touch with your local social assistance service. There is a range of solutions available.

Contact

Family assistance
Aide familiale
Familljenhaus Zentrum
T 40 49 49 400
F 40 21 31 339

Family assistance for parents of young children

You can also contact Fondation Cancer, which, together with *Europa Donna* and *Arcus*, provides a **free** family assistance service. Any patient receiving treatment for cancer, who has a child between 0 and 13 years of age and lives in Luxembourg, can benefit from this service.

Assistance can be provided for a maximum of three consecutive months and for a maximum duration of 10 hours per week, from Monday to Saturday between 6am to 10pm, excluding national holidays. Assistants help families by supporting children with their day-to-day tasks, getting them to and from school and helping with other journeys. They also check homework is completed and even help the family with cooking and cleaning.

To benefit from this service jointly funded by *Europa Donna Luxembourg* and Fondation Cancer, please contact fondation@cancer.lu or call 45 30 331.

I need care and assistance at home. Who should I contact?

A range of care and assistance networks provide services at your home. If you meet certain conditions, some of these services are paid for by the CNS, and others by your care insurance scheme.

To get assistance from a nurse (to change dressings or give injections) or a nursing assistant for everyday tasks (to help you get up, wash and get dressed), contact the healthcare and assistance networks.

Ideally, you should check with the care service whether you can make a care insurance claim.

Domestic care services take account of your individual requirements and will offer you services tailored to your needs.

They will talk with you about how the costs will be covered.

Useful info

Medical care prescribed by your doctor, such as injections and dressings, is covered by the CNS.

Coverage of the **costs of daily care/ assistance** by your care insurance is only possible under certain conditions:

- You must require care on a daily basis for at least 3.5 hours a week for a period lasting at least six months. This includes personal hygiene, mobility and nutrition (e.g. assistance for washing, getting up, getting dressed and/or eating).
- Professionals in the care insurance assessment and guidance unit (*Cellule d'évaluation et d'orientation*/CEO) make a ruling on the necessity of the assistance requested and draw up a care and assistance plan tailored to your personal needs, which is sent to you after your assessment. The costs are then covered retroactively from the date on which the care insurance request was submitted.

If you need care services (e.g. help washing or getting dressed) that are not covered by care insurance, you need to pay for these services yourself. Ask the domestic care service whether you can benefit from a subsidised rate (depending to your income).

If your condition only requires services related to your health insurance (injections, dressings) and you have a medical prescription, you can request the services of a community nurse alongside the domestic care services mentioned above.

Information and contacts

Insurance assessment and monitoring unit – *Administration d'évaluation et de contrôle de l'assurance (AEC)*
T 247-86 060
F 247-86 061
E secretariat@ad.etat.lu

For any questions related to care insurance services, contact:

CNS/Care insurance services requests
Demandes prestations assurance dépendance
T 27 57-46 05 / 46 07
F 27 57-46 19
E via a contact form

Domestic care providers

For a list of domestic care providers, please see the addresses on *Editus* under the: help at home section.

Community nurses

For community nurses, please see the addresses on *Editus* under the: community nurses and carers section.

Treatment abroad

For treatment abroad, it is important to distinguish member states of the European Union (EU), the European Economic Area (EEA) (Iceland, Liechtenstein, Norway) and Switzerland from all other countries. Among those countries outside the EU, EEA and Switzerland, there is also a difference between countries bound by bilateral agreements with Luxembourg and third countries without such an agreement. The information provided below refers specifically to countries in the EU, EEA and Switzerland.

For treatment abroad, it is also important to distinguish between **emergency** and **scheduled treatment**.

I need to have scheduled medical treatment abroad. What do I need to do? Who will cover the costs?

In the event of **inpatient** treatment abroad (involving at least one night spent in hospital), it is essential to request prior agreement from the CNS that it will cover the costs of the treatment. This is also the case for scheduled **outpatient** treatment, if highly specialised and expensive equipment is required.

- You need to make a request for an S2 form for treatment abroad from your GP or specialist doctor.
- This request must be sent by post, fax or email to the CNS, transfer abroad department, which will subsequently be forwarded to the CMSS for approval.
- This approval will be sent to you from the CMSS. There are two types of approval that can be given:
  - » **Approval via an S2 form**
    Agreement to cover the costs of scheduled treatment under the same conditions of coverage and at the same rate as people with social security insurance in the country where the treatment is being carried out.
    Costs are usually covered by a third party, which pays the costs of the treatment through a healthcare fund in the country in question.
    It is possible that the expenses incurred exceed the agreed amounts (e.g. in the event of optional services, treatment delivered by clinic director, bedroom surcharge for individual or double room, etc.). In this case, you can get information from your supplementary insurance provider about what contributions can be made towards these costs.
  - » **Approval as per Directive 2011/24/EU**
    If the healthcare provider abroad does not have an agreement in place or if you decide to receive treatment outside the country's healthcare system. This is also the case if you are having a consultation or a straightforward medical examination. In this case, the CNS shall issue an agreement to cover the treatment costs. You must pay all the costs of the treatment carried out by the care provider up front and then be reimbursed by the CNS in line with the rates and costs in place in Luxembourg (without exceeding the amounts of the actual costs incurred).

Advice

If the treatment is more expensive in the country where it is provided compared to Luxembourg (due to different statutory rates in force in different countries), an additional reimbursement can be requested from the CNS.

What you need to check before your treatment abroad:

- Check with the care provider abroad whether they accept the S2 form and whether the process to transfer the treatment to the healthcare insurance fund in the country in question has been initiated. If the care provider does not deal with this administrative process, it is advisable to check with a healthcare insurance fund in the country in question whether they accept the S2 form. In some cases, the healthcare insurance fund needs to check the conditions required to cover the medical care costs (e.g. for treatment or examinations requiring prior agreement in the country).
- When you are admitted to the hospital/seen by the doctor, make it clear that you are being treated as part of the S2 agreement and that you should be considered to be an insured person in the country in question. Make sure that the individual optional services (e.g. individual bedroom, treatment by clinic director, etc.) are only provided with your prior consent.
- If the care provider abroad does not accept the S2 form, you must pay the costs up front and request a reimbursement from the CNS in Luxembourg in accordance with Directive 2011/24/EU. During inpatient treatment in a listed establishment, the care provider should manage the process of covering the costs itself with the healthcare insurance fund in the country in question. If you receive a bill, you can ask the care provider to process the deduction with the health insurance fund in question. You can also contact the international department of the CNS, which can try to process the deduction directly with the care provider abroad.
- With regard to the agreement addressed in Directive 2011/24/EU, it is advisable to receive advance notice of the treatment costs from the care provider abroad because rates in different countries can vary substantially from rates in Luxembourg.

Advice

- **Wait until you receive the agreement of the CMSS before travelling abroad to receive medical treatment.**
- **In the event of last-minute/emergency travel abroad, your specialist can submit a request for approval by fax marked “urgent” to the CNS’s treatment abroad department, so that it**

can be processed as quickly as possible and returned to you or your doctor.

If the request is denied, you have 40 days within which you can appeal the decision in writing to the board of directors of the CNS within the 40 days.

I need to travel abroad for a single medical consultation or medical examination. Do I need prior approval and who covers the costs?

In this case, you do not need prior approval. You pay the medical costs owed to the care provider yourself and then request **a reimbursement from the CNS in accordance with the rates in force in Luxembourg**.

Ask the care provider abroad to issue a detailed breakdown of the services provided instead of simply giving a code, so that the rate applicable in Luxembourg can be used.

Check the cost of your consultation or treatment and whether additional costs may be added.

I need medical assistance urgently. How will the expenses be paid?

If you are abroad (e.g. on holiday), the required medical care will be covered by your European health insurance card.

As soon as you show this card or an equivalent document, you are **entitled to the same healthcare as any other insured person in that country**.

Do I need to cover the travel costs when I receive treatment abroad?

If you want your travel costs to be covered, you must receive prior consent by submitting a request to the CMSS. Travel costs are only covered for a maximum distance of 400km (one way). In exceptional cases, this coverage may be increased to 600km (one way).

The CNS will cover the costs of:

- Transport by ambulance: 70 % of the total cost;
- Transport by non-emergency patient transport or private car: €0.21/km (as of 2023);
- Public transport: based on expenses incurred.

Please note

- Your doctor should make the request on the back of the treatment abroad request form (S2). They can tick and justify the mode of transport (e.g. ambulance, non-emergency patient transport, plane). The request is sent to the CMSS for approval.
- If you do not return to Luxembourg on the same day, you need to request separate approvals for the outbound and return journeys. If you do a round trip on the same day for a chemotherapy treatment, for example, this is not necessary.

- If you travel in your car, are taken in someone else's private vehicle, or if you take public transport, and your healthcare has been approved by the CMSS (S2 approved), you can request a reimbursement of expenses from the CNS.
  You must prove that you attended by asking the care provider to certify your attendance. You should send this certificate to the CNS travel expenses reimbursement department as part of the S2.
- If you are travelling abroad for a simple consultation (e.g. for a diagnosis or a check-up), the CNS will only reimburse travel costs if you need to be transported by ambulance lying on your back. You do not need to request an S2 form for this. You just need your doctor to issue a prescription for this purpose.

Advice

In the event of last-minute/emergency travel abroad, your specialist can submit a request for agreement by fax marked "urgent" to the CNS's treatment abroad department, so that it can be processed as quickly as possible and returned to you or your doctor.

You can also submit the request by post or email, but the request will arrive at the relevant CNS department quicker if you send it by fax.

Somebody will accompany me for my treatment abroad. Will I need to cover the expenses of this person?

When you receive treatment abroad, the subsistence costs (accommodation and meals) of the person accompanying you shall be covered in line with the rates applicable to a person with social security insurance in the country in question. If there is no such rate (ask the hospital/care provider or the relevant healthcare insurance fund in the country in question), the expenses shall be borne by the CNS at the rate in force (€92.14/day, as of 2023).

Please note

- This must be in the case of hospital treatment or a medical consultation approved by the CMSS.
- The primary doctor abroad must justify in writing why such an accompaniment is necessary. You must attach this justification to your communication with the CNS when requesting reimbursement of subsistence expenses.

No approval is required to accompany children.

Information and contacts

CNS Department for treatment abroad – *Service transfert à l'étranger*
T 27 57-43 00
F 27 57-43 09
E via a contact form

CNS Department for international reimbursements – *Service remboursement internationaux*
T 27 57-49 60
E via a contact form

Cancer rehabilitation

Cancer and cancer treatment often have physical and mental side effects. Cancer rehabilitation helps improve the quality of life of those affected. It makes it easier to get back to everyday life and, where applicable, return to work.

I need physiotherapy or massages. Are these services reimbursed by the CNS?

To enable treatment costs to be covered by the CNS, you need a standard medical prescription relating to the illness in question, the number and frequency of treatments required and information on the treatment prescribed.

The number of treatment sessions prescribed depends on your illness.

The maximum number of prescribed sessions covered by the CNS varies depending on the type of treatment:

- A maximum of 8 sessions for a common condition;
- A maximum of 64 sessions for a serious condition;
- A maximum of 32 sessions for post-surgery rehabilitation.

Serious conditions are defined in appendix G of the statutes of the CNS and are also stated on the back of a standard medical prescription.

The rate of coverage of the costs is set at 70 % for treatment in the case of a common condition. 100 % of costs are covered for treatment for serious conditions or for post-surgery rehabilitation, as well as treatment for children under 18.

Specific examples

- **You need lymphatic drainage after treatment for breast cancer**.
  After undergoing surgery or radiotherapy for breast cancer, your doctor may prescribe lymphatic drainage to prevent your arm from swelling. 100 % of the costs of this treatment is covered by the CNS.
- **You need rehabilitation after treatment for prostate cancer.**
  After undergoing treatment for prostate cancer, your quality of life can be affected by incontinence of varying degrees of severity. Pelvic rehabilitation sessions can help to strengthen the urethral sphincter and perineal muscles, allowing you to improve your bladder control. Your doctor will recommend the physiotherapy that is right for you. In general, following a surgical procedure, 100 % of the cost of this treatment is borne by the CNS.

Useful info

- You or your physio must send your medical prescription to the CNS for approval. The CNS will send you a certificate stating that the costs will be covered.
- If the physio comes to your home, the CNS will cover a fixed rate cost (€12.88, as of September 2023). Your doctor must state on your prescription that you require treatment at home.
- Methods for paying costs:
  - » through the third-party payment system.

You only pay your personal statutory contribution to the physiotherapist. They then send an invoice to the CNS at the end of the treatment to receive the portion covered by the CNS. Your physio will issue you with a medical prescription with a statement of the fees charged, showing your personal contribution and the amount covered by the CNS.

The third-party payment system can only be used if the physio sends the medical prescription directly to the CNS for approval. If you requested approval yourself, you need to pay the physio up front yourself and then request a reimbursement from the CNS. Remember also, all treatments must be provided in Luxembourg.

- » you pay all costs up front.

You receive a bill from your physio stating the full amount payable. After paying the bill, you can send it to the CNS for reimbursement.

What Fondation Cancer offers:

Fondation Cancer offers exercise classes for people affected by cancer, including gym classes, muscular stimulation and yoga, among others.

Click the link below for free sport offers and other classes and groups organised by Fondation Cancer.

You can also find other offers provided by ALGSO (Luxembourg association for sports groups for cancer patients/l'*Association Luxembourgeoise des Groupes Sportifs Oncologiques a.s.b.l.*).

I want to start a rehabilitation programme/course of treatment. What do I need to know?

In Luxembourg, there are various inpatient and outpatient cancer rehabilitation programmes available. These multidisciplinary services include various components, such as physiotherapy, sports therapy, nutritional advice, psycho-oncology and social counselling.

Cancer rehabilitation

The Château de Colpach rehabilitation centre (CRCC) hosts the National Cancer Rehabilitation Service (SNRPO) and offers hospital follow-up for cancer patients, with a wide range of services. There are 20 places available.

At the CRCC, patients suffering following their illness or treatment can receive cancer rehabilitation in a hospital setting. The rehabilitation programme lasts

between 21 and 30 days. The priorities of the rehabilitation are recovery, reducing functional limitations, improving autonomy and a general improvement in quality of life.

A multidisciplinary team (doctors, nurses, occupational therapists and physiotherapists, psychosocial services, etc.) supports patients with a tailored course of treatment, created after conducting a needs analysis

Useful info

Your primary doctor needs to send a request for admission at the CRCC. They can use the form available on the website to do so.

The doctor at the centre will process the request and decide whether to approve it.

The CNS will cover all the costs of the rehabilitation, except for a personal contribution of around €25.50 per day, situation in 2023.

Contact

Château de Colpach rehabilitation centre – *Centre de réhabilitation du Château de Colpach*
T 27 55 43 00
E crcc@croix-rouge.lu

Medical spa treatment

You can follow a medical spa treatment at the *Domaine thermal Mondorf* in Mondorf-les-Bains.

Please note

- You need to be recommended by your primary doctor.
- Book an appointment with one of the doctors at the *Domaine thermal Mondorf*.
- The doctor submits the approval request to the CNS.
- After approval from the CNS, you will receive confirmation of coverage of the costs valid for one year.
- You need to pay for your accommodation costs and will then be reimbursed at the daily rate by the CNS in a hotel approved by the CNS.
- The CNS will reimburse up to 87.40 % of your thermal treatment costs.

The *Domaine thermal Mondorf* manages the payment of this amount directly with the CNS. The amount that remains payable by you must be paid on the first day of your stay.

For more information, contact:

Contact

Mondorf Domaine Thermal
T 23 666-800
F 23 666 -557
E domaine@mondorf.lu

Can I go on a cancer rehabilitation stay abroad?

A cancer rehabilitation stay abroad is only possible if the specific care required is not available in Luxembourg.

You would require approval from the CMSS, but it is rare for such requests to be approved.

Palliative care

When a patient's situation is terminal as a result of their cancer, palliative care can be provided to the person at the end of their life to relieve pain and maintain a certain quality of life.

To receive palliative care, you must first speak to your primary doctor and ask them to submit a declaration to the social security medical department. This declaration is made using a specific form stating the way in which the entitlement to palliative care is allocated.

The medical department then takes a decision on the medical eligibility after consulting the doctors who signed off on the declaration. After approval is given, entitlement to palliative care is valid for a period of **35 days**. This period can always be renewed for one or more additional 35-day periods, subject to the duly justified reasoning of the primary doctor only.

The CNS will then issue an approval for covering the costs, which will be sent to the primary doctor and the care providers of the patient in question. The doctor must attach this approval to the medical care record.

Palliative care can be provided at **a hospital**, in an establishment recognised by the legislation on healthcare and care insurance, or **at home**. Care networks and hospitals have **mobile palliative care teams**.

Palliative care provision in Luxembourg

Inpatient care units:

Luxembourg City Hospital –
Centre Hospitalier de Luxembourg
(Care unit with ten beds and a mobile team)
CHL Eich
E pallia.sec@chl.lu
T 44 11 79 03

Hospital du Nord –
Centre Hospitalier du Nord
(Care unit with six beds and an internal and external mobile team)
CHdN
E chdn@chdn.lu
T 81 66 51 530

Emile Mayrisch Hospital –
Centre Hospitalier Emile Mayrisch
(Care unit with eight beds)
CHEM Small building, floor 3
T 57 11 33 001

Haus Omega
(Palliative care centre with 15 beds)
E info@hausomega.lu
T 26 00 37 1

Robert Schuman Hospitals –
Hôpitaux Robert Schuman
(Care unit with eight beds)
ZithaKlinik
T 28 88 40 23

Care at home:

HELP – Doheem Versuergt
Palliative care home
E info@help.lu
T 27 55 35 70

Päiperléck S.à.r.l.
Nuets Päiperléck
E info@paiperleck.lu
T 24 25 14

Stëftung Hëllef Doheem
E info@shd.lu
T 40 20 80

Special leave

Employees are entitled to two types of special leave: **carers leave** and **compassionate leave to provide end-of-life care** to a loved one.

Carers leave

Special carers leave can be granted for a maximum duration of **five days** over a period of 12 months if a family member or person living in the same household requires personal care or assistance for a **serious medical reason** certified by a doctor.

You must inform your employer from the first day you are off work. No later than the third day off work, you must provide your employer with a medical certificate and a document proving your family link to the person in need of care or the fact that you live in the same household.

Information and contacts

Ministry of Labour, Employment and the Social Economy – *Ministère du Travail, de l'Emploi et de l'Économie sociale et solidaire*
Special leave department
T 2478-6130

Compassionate leave to provide end-of-life care

Compassionate leave to support a person through end-of-life care can be requested by anyone who works, if a loved one is suffering from a **serious terminal illness**. The duration of the leave cannot exceed **five working days** (or 40 hours) for each loved one per year. It ends on the date when your loved one passes away.

The person making the request must inform their employer from the first day off.

They must also complete a compassionate leave to provide end-of-life care form, which must be sent to the CNS, along with a statement confirming the allocation of compassionate leave signed by the patient's doctor.

When confirming the allocation of this leave, the CNS will send **a care record, which includes a *Justification of absence for compassionate leave*** to submit to your employer.

Information and contacts

CNS - Financial compensation – *Indemnités pécuniaires*
T 27 57 - 1

II. Cancer-related costs

Methods of payment of expenses by the CNS

In general, the coverage of healthcare costs is based on the **principle of reimbursement of up-front payment of expenses**. As such, you pay any bills you receive up front. The healthcare costs are then reimbursed in part or in full by the CNS, depending on the type of care (e.g. inpatient or outpatient care).

The **third-party payment system** is used for some types of care (e.g. medicine, hospital expenses, physiotherapy, etc.), where costs are paid by the CNS to care providers directly. In these cases, you only pay the portion of the costs (your statutory personal contribution) that the CNS does not cover.

For the CNS to cover healthcare costs, they must:

- Be delivered by providers who have signed an agreement with the CNS;
- Be provided for in the statutes of the CNS;
- Be stated in the Social Security Code, included in the nomenclatures or referenced in the lists/files of the CNS.

Medical consultations, excluding hospital treatment, are reimbursed at an official rate of 88 %. The cost of chemotherapy, immunotherapy, targeted therapy and radiotherapy are covered in full.

If you are affiliated to a supplementary insurance scheme (e.g. *Caisse médico-complémentaire mutualiste*/CMCM), you may be entitled to additional reimbursement or coverage. You can check the details of this with your supplementary insurance provider.

Hospital and treatment costs

As soon as cancer is diagnosed, there will inevitably be questions about the costs of treatment. This section will give you answers to the most frequently asked questions about hospital and treatment costs.

I am hospitalised in a standard room. What costs do I need to cover?

If your stay in hospital lasts longer than three days, this is classed as "hospital treatment". You need to pay a portion of the hospital stay fees equating to €25.50 per day in a standard room (as of September 2023). This counts for every day of hospital treatment, as soon as each new day begins, up to a maximum of 30 days per calendar year.

In general, bills for your hospital stay (medical visits, examinations, etc.) will be sent directly to the CNS by the hospital. However, if you do receive a bill related to your hospital treatment, the following options are open to you:

- You pay the bill(s) and send it/them to the CNS for reimbursement (100 %).
- If the amount of the bill is higher than €100, you can ask the doctor to send it personally to the CNS for payment.

I am hospitalised in a private room. What costs do I need to cover?

If you stay in a private hospital room (room with one bed), the costs of the stay, as well as the costs of medical visits, treatment and surgeries are higher than for a standard room. You must cover the costs of this additional expense yourself. The surcharge for a private room varies depending on the type of room. Medical services and procedures increase in cost by 66 % compared to a standard room rate. If you have supplementary insurance, you can get information on what additional costs are covered.

I am receiving outpatient treatment. What costs do I need to cover?

For outpatient treatment, meaning that you only go to hospital for treatment but do not need to stay overnight, bills for medical visits and examinations are sent to your home address, which you need to pay before requesting reimbursement from the CNS.

In general, cancer treatments (e.g. chemotherapy, radiotherapy, etc.) are billed directly by the hospital to the CNS (third-party payment system). If this is not the case, you can ask your doctor to send the bills directly to the CNS.

What should I do if the amount of a bill for an examination or treatment is so high that I cannot afford to pay it?

If you receive a medical bill that you cannot pay because you are in a temporarily challenging economic situation, the CNS can pay the bill directly to the care provider, subject to a justified request.

To do this:

- The bill must be for treatment costs that are reimbursed by the CNS.
- It must be a medical bill exceeding €250. It must not be more than 3 months old. A separate request must be made for each medical bill.

The CNS pays the service provider the amount that it would have reimbursed to you if you had paid the bill. In this particular situation, you will receive from the CNS a statement showing the amount that has already been paid by the CNS and the amount that remains to be paid by you to the service provider (statutory personal contribution).

I paid a very expensive bill for treatment costs. Is it possible to be reimbursed more quickly?

If you paid your medical bills yourself, you can be reimbursed by the CNS by cheque.

To do this:

- The date of payment of the medical bill must not be more than 15 days ago.
- The bills, either individually or combined if you paid several bills over the period, must be for a total amount of at least €100.
- You can cash the cheque received from one of the CNS agencies at branches of the *POST* for no additional fee.

I can't afford to pay my personal contribution. Is there a cap on the amount?

If the personal contribution for your healthcare costs exceeds the threshold of 2.5 % of your annual taxable income from the previous year, you are entitled to request a **supplementary reimbursement** of the amount that exceeds this threshold.

Advice

- **The latest reimbursement statement from the CNS shows you the amount of your personal contribution.**
- **If this amount is higher than 2.5% of your annual taxable income from the previous year, you can request a reimbursement from the CNS.**
- **For example:**
  If in 2022, your gross annual income was €36,000, the threshold for 2023 is 2.5% of €36,000 = €900. Therefore, with a gross annual income of €36,000, the threshold is reached if the overall amount is higher than €900. You can therefore submit a request if your overall contribution in the course of a calendar year (from 1 Jan to 31 Dec) exceeds €900. If, during the course of 2023, you paid contributions for a total of €1,050 on the date of your declaration, you can request a supplementary reimbursement of €150 (€1,050 - €900 = €150).

You need to complete an online form for a supplementary reimbursement, and you also need to make your request before the deadlines in force.

I often have problems paying my medical bills. What options are available to me?

You can request a third-party social payment (TPS), which is the direct payment of costs for people on a low income. If you are allocated third-party social payment status, the social security office in your municipality will issue you with a statement and a book of tokens that you can use for direct reimbursement of the service provider by the CNS.

Useful info

Contact the social security office in your municipality. They will process your request and decide whether you are entitled to TPS.

During a medical consultation, you can provide the tokens received by the social security office to the doctor. The doctor will then send the bill, with the token attached, directly to the CNS. If the bill is sent to your address, stick the token on the bill yourself and send it to the CNS.

If you are in a challenging economic situation, it may be helpful to speak to the social security office in your municipality. Further support options may also be available to you.

Personal contribution to purchase medical devices and medicine

Most medical devices and the amount covered are listed under different sections in the statutes of the CNS (sections B1-B7).

Section B1 lists small-scale medical devices such as **special dressings, products for urinary incontinence**, glucose monitors and accessories.

Section B2 features more large-scale equipment, which is only provided on a **lease basis** (with a leasing contract).

Section B3 lists all devices, attachments and accessories for **hearing correction**.

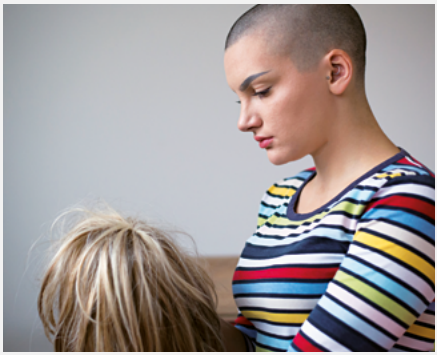
Section B4 includes medical devices for people who have undergone a **laryngectomy** or **tracheotomy** or for people with another **respiratory illness**.

Section B5 lists **medical nutrition** products.

Section B6 sets out the **travel and transport services covered** by the CNS.

Section B7 lists medical devices that can only be medically prescribed for hospitals for treatments administered outside hospitals.

I need a wig. Will it be reimbursed by the CNS?



If you buy a wig, the CNS will reimburse you a fixed lump sum of €350 (as of September 2023). If you have supplementary healthcare insurance, contact the insurance provider to find out what additional contribution they may make.

You are entitled to a prescription to buy a wig every year.

Please note

- You need a medical prescription.
- Send a copy of it to the CNS. They will send back a statement confirming that they will cover the costs.
- To get reimbursed for your purchase, send the CNS the original version of the prescription, the statement confirming they will cover the costs and the receipt for the purchase.

Since no prior approval is required from the CMSS, you can send your prescription to the CNS and buy your wig straight away. Please follow the process described above to get your reimbursement.

Your prescription is valid for three months. The reimbursement request can be submitted within a period of two years, providing you are affiliated to the CNS during this period (ensuring that you comply with the three-month validity of the prescription).

Fondation Cancer advises you to choose your wig before losing your hair. In this way, the colour, volume and style of the wig can be better tailored to match your current haircut.

Upon request, you can receive a list of wig suppliers from Fondation Cancer.

Contact

Fondation Cancer
T 45 30 33 1
E patients@cancer.lu

CNS medicine authorisation service – *Service autorisations - médicaments*
T 2757-4599 - F 407850
E via a contact form

I need a breast prosthesis. Will it be reimbursed by the CNS?

After a mastectomy, you can choose from different types of external breast prostheses:

- A temporary foam prosthesis (for the period immediately post-operation);
- An external silicone prosthesis;
- Self-adhesive external silicone prosthesis.

Remember that:

- You need a prescription for all these external prostheses in order to be reimbursed by the CNS;
- The CNS will reimburse the following amounts (as of 2023)
  - » temporary foam prosthesis €20 (each)/€40 (pair)
  - » external silicone prosthesis €205.75 (each)/€411.50 (pair)
  - » self-adhesive external prosthesis €252.85 (each)/€505.70 (pair)
- If you have supplementary healthcare insurance, you can ask for information on what additional contribution they may make.

You are entitled to a new prosthesis every year without requiring a new medical prescription.

You can also request a consultation with a breast care nurse at the hospital where you are being treated. A breast care nurse is a nurse specialised in caring for patients affected by breast cancer.

A range of shops sell special bras and swimming costumes. There is a wide selection available. However, these items are not reimbursed by the CNS.

Where can I buy an external breast prosthesis?

Upon request, you can receive a list of suppliers of external breast prostheses from Fondation Cancer.

Contact

Fondation Cancer
T 45 30 33 1
E patients@cancer.lu

CNS medicine authorisation service – *Service autorisations - médicaments*
T 2757-4599
E via a contact form

Knitted breast prosthesis *(Knockers)*

Knockers are an alternative to silicone medical prostheses for women who have had a mastectomy. These knitted breast prostheses are a natural cup size and are padded with cotton. Knockers are supplied by ***Knitted Knockers***.

I need medical devices such as an ostomy pouch or products for incontinence. Does the CNS cover the cost of these items?

Most medical devices and the amount covered are listed in the various sections of the downloadable statutes of the CNS:

- Section B1 lists small-scale medical devices such as special dressings, products for urinary incontinence, glucose monitors and accessories.

Please note

- You need a medical prescription.
- To ensure that the CNS covers/contributes to the cost, your doctor should only prescribe devices (products/brands) listed by the CNS.

Contact

CNS medicine authorisation service – *Service autorisations - médicaments*
T 27 57-45 99
F 40 78 50
E via a contact form

At home, I need to feed through a tube. Do I have to cover the costs?

The CNS covers the costs, up to €768.75 per six-month period (as of March 2023), of feeding exclusively through a tube (enteral nutrition), if this is prescribed in the event of ENT cancer or cancer of the upper digestive organs.

Section B5 lists medical nutrition products.

Please note

- Prior approval from the CMSS is required for the CNS to cover the costs.
- Your doctor needs to send a medical report on your state of health for assessment and approval by the CMSS. If approved, you will receive confirmation in writing.
- It is advisable to wait for this approval before buying the products.
- Your doctor will issue you with a medical prescription (for a maximum of six months).

To get reimbursed, send your receipts with the corresponding prescription to the CNS.

Contact

CNS medicine authorisation service – *Service autorisations - médicaments*
T 27 57-45 99
F 40 78 50
E via a contact form

I need a wheelchair, a pressure relief mattress or other technical equipment. Where can I get them and who covers the costs?

Nursing care equipment such as hydraulic beds, wheelchairs and pressure relief mattresses can be leased without charge from the SMA (accessory equipment service/*Service moyens accessoires*). The leasing costs are covered by the CNS. The equipment will be delivered to your home.

You need a medical prescription. Contact the below service once you have your prescription:

Accessory Equipment Service – *Service Moyens Accessoires*
T 40 57 33 1
F 40 95 17
Msg 621 340 257

If the equipment is still required after six months, a renewal request must be sent to the CNS along with a new medical prescription.

If your primary doctor decides that a technical device will be necessary permanently, it is advisable to request the relevant request form from the care insurance office (see page headed Care and assistance at home). If the technical assistance is provided as part of your care insurance, then it will cover the costs of the leased equipment.

To ensure that the costs of this technical equipment are covered, you should not buy it yourself, because these purchases are generally not reimbursed.

Contact

CNS treatment and supplies authorisation service – *Service autorisations - traitements et fournitures*
T 27 57-1
F 26 48 28 71
E via a contact form

What do I need to know about getting medicine reimbursed?

The CNS covers between 40 % and 80 % of the cost of prescription-only medicine. Providing that you provide the pharmacy with your medical prescription, the third-party payment system will apply. You will pay your statutory personal contribution (between 20 % and 60 %) upon receiving the medicine. Consult the statutes of the CNS to see the positive list of medicine (list of medicine covered by the CNS)
In some clearly specified cases, with prior authorisation from the CMSS, the CNS will cover 100 % of the costs of medicine. For instance, this applies to:

- bisphosphonates (medicine that slows down bone deterioration) in cases of cancer ;
- major morphine-derivative analgesics prescribed to patients with cancer;
- analgesics prescribed to patients with an entitlement to palliative care in accordance with Article 1 of Luxembourg Law of 16 March 2009 on palliative care, advance healthcare directives and end-of-life care.

Contact

CNS medicine authorisation service – *Service autorisations - médicaments*
T 27 57-45 99
F 40 78 50
E via a contact form

Transport costs to cancer services

If you need to go to hospital for ongoing medical treatment (repeated therapy sessions) such as chemotherapy or radiotherapy, the CNS can cover ongoing transport costs:

- by taxi (Luxembourg and abroad);
- by ambulance (Luxembourg and abroad);
- by private car/own transport method (Luxembourg and abroad);

depending on your state of health.

This is also the case if you travel to the national functional rehabilitation and readaptation centre *(Centre national de rééducation fonctionnelle et de réadaptation)* for at least four sessions of treatment within a period of 90 days.

For transport in Luxembourg

If you use your own mode of transport

If you use your own mode of transport, you can request reimbursement of travel costs from the CNS. It will reimburse you (€0.20/km, as of 2023) for the shortest journey between your home and your place of treatment. You need to complete a form and send it to the CNS, along with a certificate of attendance for the dates of treatment, filled in by your doctor.

If you take a taxi (non-emergency patient transport)

If you take a taxi (non-emergency patient transport), you must follow this process:

- Ask your primary doctor to complete the form entitled Request for payment of ongoing transport costs by healthcare insurance and send it to the CNS, in the event of chemotherapy or radiotherapy. Ongoing transport by taxi to the national functional rehabilitation and readaptation centre are only covered for a maximum of 20 days of treatment.
- Wait until you receive the approval from the CNS that the costs will be covered. You need this prior approval before your first journey.
- You must use a taxi company that is approved by the CNS. You receive the list of companies attached to your approval. Choose the taxi company that is closest to your home because only the price for the shortest route between your home and the place of treatment is reimbursed. Make sure to check the price applied by the taxi company to avoid having to pay any additional costs yourself. The CNS will only reimburse the agreed price (see below). It is also important to remember that you may need to cover some of the costs. You can negotiate with the taxi company whether you pay the bill and get reimbursed by the CNS or if you give the approval notice to the taxi company which then gets reimbursed by the CNS, leaving you to pay only those costs that are not covered by healthcare insurance.
- The CNS will reimburse you:
  - » a lump sum of a minimum of €6.56/journey (e.g. in the event of a short 3km-journey)
  - » €1.64/km for a one-way trip
  - » €0.82/km for the shortest round trip

between your home and the place of treatment (as of 2023).

If you travel by ambulance

If you need to use an ambulance, the conditions for having the costs covered and the process to follow are basically the same as for transport by taxi, except:

- Travel by ambulance is only authorised if you need to be transported lying down or immobilised. Your doctor needs to justify the medical reasons for this.
- The CNS will reimburse €1.29/km (round trip) or a fixed sum of a minimum of €39.07 (e.g. short trip) (as of 2023).
- The company providing the transport may charge more than the contribution from the CNS. In this case, you need to cover the additional costs.

Contact

CNS
T 27 57-1
F 27 57-27 58
E via a contact form

For transport abroad

For costs of travelling abroad to be covered, you need prior approval from the CMSS. Travel costs are only covered for a maximum distance of 400km (one way). In exceptional cases, journeys of up to 600km (one way) can be covered.

Remember that:

- Your doctor must make such a request on the back of your form for requesting approval for treatment abroad (S2). They can tick and provide justification for the mode of transport (e.g. ambulance, non-emergency patient transport, plane). This request is then sent to the CMSS for approval.
- If you do not return to Luxembourg on the same day, you need to request separate approval for the outbound and return journeys. If you are doing a round trip on the same day, for a chemotherapy treatment, for example, this is not necessary.
- If you travel in your car, are taken in someone else's private vehicle, or if you take public transport, and your healthcare has been approved by the CMSS (S2 approved), you can request a reimbursement of travel expenses from the CNS. You must prove that you attended by asking the care provider to certify your attendance. You should send this certificate to the CNS travel expenses reimbursement department as part of the S2.
- If you are travelling abroad for a simple consultation (e.g. for a diagnosis or a check-up), the CNS will only reimburse travel costs if you need to be transported by ambulance lying on your back. You do not need to request an S2 form for this. You just need your doctor to issue a prescription for this purpose.

Contact

CNS - Travel abroad department – *Service Transfert à l'étranger*
T 2757 - 4300
E via a contact form

Tax issues

When you are diagnosed with cancer, questions inevitably arise regarding the costs related to your illness and tax-related issues. In this section, you will find answers to the most frequently asked questions.

Are the costs related to my illness tax-deductible?

Costs related to your illness that are not reimbursed (contribution stated on the back of the statement provided by your healthcare insurance and the contribution billed by the hospital) or costs of domestic assistance and/or childcare, are deemed to be extraordinary costs, which makes them tax-deductible.

How can I benefit from this tax relief?

On your tax return, you can list these costs under the 'extraordinary costs' section.

- These extraordinary costs give rise to tax relief on your taxable income. This relief is calculated according to your financial and family situation (income, number of dependent children).
- A lump sum allowance is a second option, which can sometimes be more beneficial to you. It can only be requested for costs arising from domestic assistance, medical and care services (state of dependence) or childcare, providing that the person providing these services is declared to the CCSS or is part of a service recognised by the state.

If you submit a request for both types of relief, the tax office will grant the one which is the most favourable for you, since you can never combine both types of relief.

Disability and tax: what you need to know

You can benefit from three tax benefits:

- If you are an employee and your capacity for work is limited by at least 25 %, the amount that you can deduct for acquisition expenses will be increased.
  Please note: you need a medical certificate that proves the extent of your disability. This certificate needs to be attached to your tax return.
- You can get tax relief on extraordinary costs, regardless of whether you are self-employed or not. The amount of this tax relief depends on the extent of your disability.
  You can also get relief for extraordinary costs that take account of expenses you actually incur (regardless of whether you are an employer or not). This will replace the lump sum allowance and the amount granted will depend on your family circumstances and financial situation.
  Please note: you need a medical certificate that proves the extent and nature of your disability. This certificate needs to be attached to your tax return.
- If you hold a disability card marked 'B' or 'C', you can get full tax exemption for motor vehicles
  Please note: You need to make a request by sending a tax exemption request form for road vehicles to the Customs and Excises Office (l'*Administration des*

Douanes et Accises (motor vehicle tax department) and attach a copy of your disability card.

Tax Office
Customs and Excises Office (Directorate)
- *Administration des contributions*
Administration des douanes et accises (Direction)
T 28 18 28 18 (switchboard)
T 27 48 84 88 (annual car tax)
E douanes@do.etat.lu

Financial assistance

Fondation Cancer can offer financial assistance to people in a challenging situation due to their cancer and who meet certain criteria. Please get in touch with us for a confidential discussion on the possibility of receiving financial assistance.

Contact

Fondation Cancer
T 45 30 33 1
E fondation@cancer.lu

III. Cancer and working life

If you have cancer and are unable to work, you probably have a lot of questions. Do I need to let my employer know about my cancer diagnosis? What consequences may it have on my employment while I am fighting cancer or unable to work? Am I allowed to travel abroad during my sick leave?
All of these questions are addressed in this section to give you the information you need to tackle this challenging situation with confidence. It is also important to know your rights and what measures you can take.

Incapacity for work

What should I check if I am ill and unable to work?

You are insured by the CNS

From your first day off, you must let your employer know that you are unable to work, regardless of how long you are ill for. You must submit a medical certificate confirming your incapacity for work to the CNS and your employer no later than the end of the third working day. You should therefore make sure that you send your medical certificate as quickly as possible!

If you are admitted to hospital in an emergency, you have eight days in which to send the medical certificate to your employer.

The form confirming your incapacity for work that you receive from your doctor has three parts. Part 1 must be sent to the CNS, part 2 is for your employer. This part does not disclose your diagnosis (due to medical confidentiality). Part 3 of the form is for you to keep.

You are self-employed

You must send the first page of the certificate confirming your incapacity for work to the CNS before the end of the third day of the period in which you are unable to work. If you are also affiliated to the Employers' Mutual Insurance Scheme *(Mutualité des Employeurs/*MDE*)*, you could receive financial compensation for your incapacity for work.

MDE - Employers' Mutual Insurance Scheme – *Mutualité des Employeurs*
L-2975 Luxembourg
T 40 141-1
F 27 57 43 43
E via a contact form

You are affiliated to a public sector insurance fund (CMFEP, CMFEC, EM-CFL)

You must let your employer know from the very first day of your period off work.
By the fourth day, your employer must have received the medical certificate confirming your incapacity for work.
Get more information from your insurance fund **about the legal provisions on sickness and employment** specific to your scheme.

Do I need to let my employer know that I have cancer?

You must let your employer know that you are off work due to illness. You also need to submit the medical certificate confirming your incapacity for work to the CNS and your employer within the deadlines given. However, you do not need to tell your employer about the nature of your illness. You do not need to submit any medical results.

Nevertheless, if a long period of sick leave is predicted, it is advisable to let your employer and/or your manager know. Remember that your manager needs to be able to organise things in your absence and may need to distribute your tasks among other colleagues or even hire a temporary replacement.

The question of whether or not to speak openly with your colleagues and managers about your cancer depends on a range of factors: Have you built up a strong level of trust with your colleagues and employer? Do you know about a similar case in your company where a colleague had cancer? How are you currently feeling about it? Are you really able to talk about your illness or are you still in shock following the diagnosis?

Fondation Cancer can provide you with a Guide for employees upon request.

Can I be made redundant because I have cancer or while I am unable to work?

Providing that you have fulfilled your obligations (informing the necessary people on the first day off work and submitting the medical certificate no later than the third day off work, or within eight days for cases of hospitalisation), you are protected from being made redundant for 26 weeks.

After this period, your employer can terminate your employment contract in accordance with legal provisions on the matter. However, to do this, your employer must provide a justified reason for the redundancy.

Remember, it is illegal to make an employee redundant during the period of protection, regardless of whether notice is given or not!

If you return to work following an uninterrupted absence of more than six weeks due to illness or accident, your employer must inform the company's occupational health doctor. The occupational health doctor will then decide whether the employee needs to have a medical examination. He will then determine whether the employee is ready to return to their previous role, whether their role needs to be adapted or whether a redeployment is necessary.

Advice

If your employment contract is terminated at the end of the period of protection, you can contact the CMSS to talk about a possible external redeployment (see the return to work section) and, if applicable, initiate the process.

During my sick leave, what do I need to know about when I can leave the house?

During your period of incapacity for work, **you are not allowed to go out during the first five days of this period, despite anything that may be stated on your medical certificate confirming your incapacity for work**, except, of course, for medical visits or treatment.

You can go to a restaurant for meals from the first day of your time off work, but you must let the CNS know in advance (by phone, fax or email).

If your medical certificate authorises you to go out, you can only leave the house from day six of your time off between 10am and midday and 2pm and 6pm.

- You may not go to a café or restaurant, unless you are having a meal.
- You may not take part in sports competitions or do activities that are unsuitable for your state of health.

Advice

From day 43 of your sick leave, you can request to extend the amount of time you spend out of the house (e.g. to go to the cinema, theatre, etc.) without requiring a medical note. You can send your request by fax or email to the CNS and you should receive confirmation soon after.

Contact

CNS Investigations and administrative monitoring department – *Service Enquêtes et contrôles administratifs*
T 27 57 43 31/32/34
E via a contact form

Can I travel abroad during my sick leave?

Subject to prior approval, the CMSS can authorise a trip abroad for a fixed period of time while you have cancer. This is also the case if you are entitled to palliative care.

- You need to submit a request (stating the location and duration) along with a letter of approval from your primary doctor to the CNS.
- Once the CMSS has approved the request, the CNS will send you a notice of the approval to your home address.

Contact

CNS
T 27 57-1
F 27 57-27 58
E via a contact form

Will I continue to get paid and receive sick pay?

Your employer will continue to pay your salary until the end of the calendar month during which day 77 of your period of incapacity for work falls. The number of days off work due to incapacity over the last 18 months are counted and the employer will pay you up to the end of the month on which day 77 of this period falls.

Thereafter, the CNS takes over by providing sick pay. The moment when the CNS takes over depends on whether you were sick for an uninterrupted period or intermittently. For example, in the event of an uninterrupted period, the CNS takes over after three months of sick leave.

How long can I receive pay for?
You are entitled to receive financial support for sick leave (continued salary payment/sick pay) for 78 weeks over a reference period of 104 weeks.

After each period of sick leave, the CNS recalculates the sum total of sick days taken retrospectively over the last two-year period. Sick pay is no longer provided once the total duration of the periods of incapacity for work exceeds 78 weeks. The CNS will send you a calculation of the date on which your sick pay will end if you are approaching 78 weeks off work due to incapacity and you are still unwell.

The amount of sick pay you receive will correspond roughly to your base salary.

Advice

If you work in between two periods of sick leave, the weeks you take off due to incapacity will be added together! The 78-week rule is calculated on an ongoing basis and does not reset for each calendar year.

- **When calculating your sick leave, all periods of sick leave are counted (whether you were off work due to the flu, a broken leg or cancer).**
- **If your periods of incapacity for work exceed a total of 78 weeks, it does not matter whether they were consecutive or not (during a reference period of 104 weeks). In this case, you will no longer receive sick pay and you will therefore need to switch to another social security scheme.**
- **Your employment contract will be automatically terminated. Ideally, steps will have already been taken to switch to a different social security scheme before the 78-week limit is reached.**

Will the CMSS ask me to take a medical examination?

If you are on long-term sick leave, you will normally be invited by the CMSS to have a medical examination carried out (after 6-10 weeks).

Advice

It may be useful to take a detailed report from your primary doctor to this appointment.

The 78-week rule

What should I know about the 78-week rule?

You can think of the 104-week (24-month) reference period as a kind of moving time frame. When the CNS receives a certificate confirming somebody's incapacity for work, it looks at the time frame of the person in question and adds up the number of sick days they have taken during that 104-week period. All certificates confirming an incapacity for work count, regardless of the reason (flu, broken bone, cancer, etc.). By counting up these days of sick leave, the person in question can estimate how many days or weeks of sick leave they have left.

The monthly statement showing a breakdown of your sick pay provides information on the number of days remaining before you reach the total of 78 weeks of incapacity for work.

Some practical, illustrative examples

If a certificate confirming a person's incapacity for work is issued on 9 February 2022, the certificate for July to August 2020 falls within the 104-week time frame.

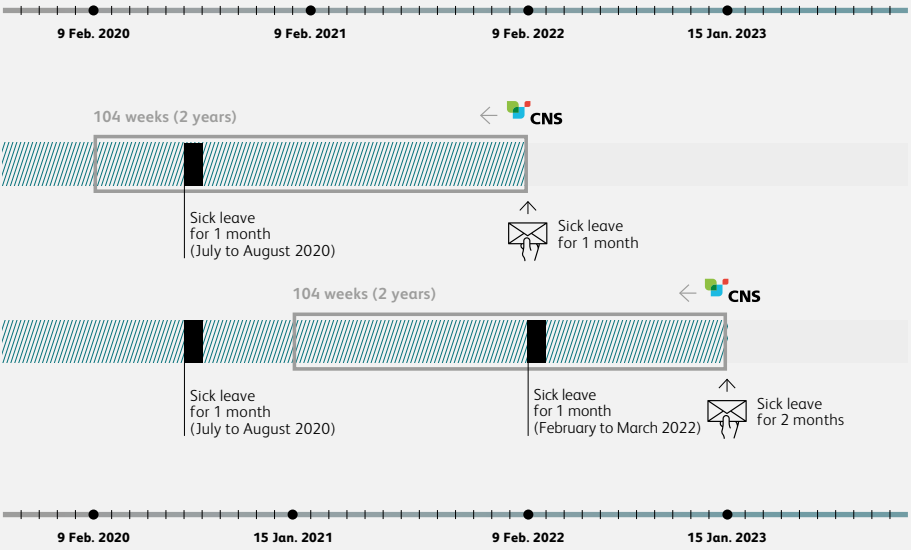
Taking the time frame into account when submitting a new certificate on 15 January 2023, the certificate from July/August 2020 then falls outside the calculation period.

N.B. All figures and calculations illustrate the fundamental principle and do not intend to represent the details of the complex calculation models used by the CNS for individual situations.

Calendar weeks

Sick leave

Reference period (104 weeks)

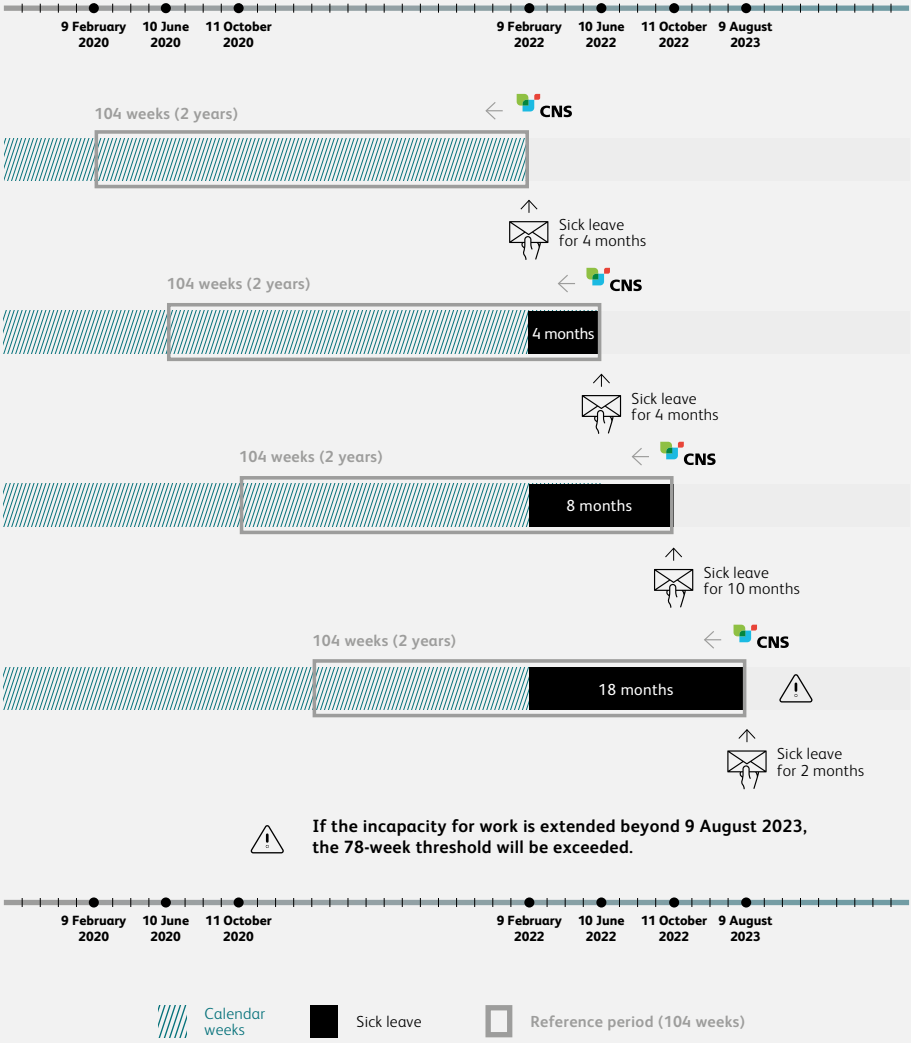


Scenario 1

You haven't been declared unable to work at any time during the two years prior to your cancer diagnosis in 2022. At the start of February, you submit a certificate confirming your incapacity for work for four months.

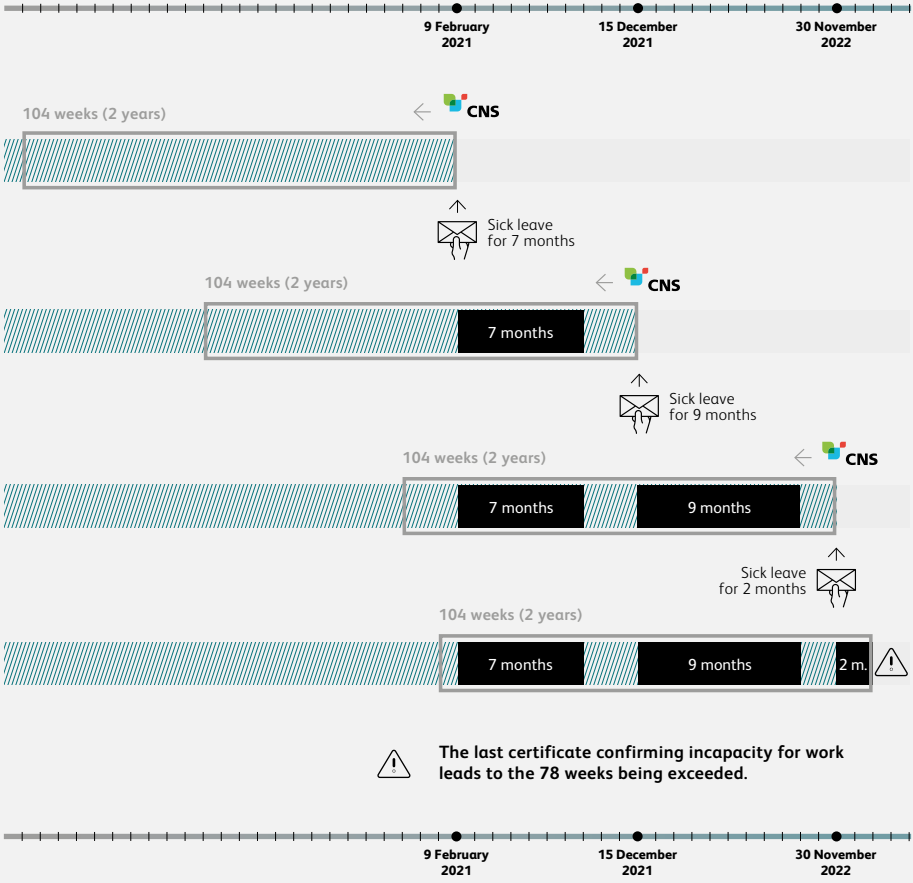
Subsequently, you submit a series of sick leave certificates and almost reach the 78-week limit over a 1.5-year period.

If the incapacity for work is extended beyond 9 August 2023, the 78-week threshold will be exceeded.



Scenario 2

You haven't been declared unable to work at any time during the two years prior to your cancer diagnosis. You submit your first certificate confirming your incapacity for work at the start of February 2021 for a duration of seven months. You return to work, but you need to go on leave on various occasions. You reach the 78-week limit over a 2-year period. The final certificate confirming your incapacity for work causes you to exceed the 78 weeks.



The CNS will send you a theoretical simulation of the date on which your sick pay will come to an end, if you are approaching the 78-week limit and you are still unwell.

Return to work

If you return to work after taking more than six weeks off, your employer has to inform the occupational health doctors from the SST (Occupational Health Services/*Services de Santé au Travail*). It is mandatory for an occupational health doctor to conduct an examination to check you are ready to return to work, ideally before the day you restart or on the day itself. If applicable, you can request an appointment with a doctor from the SST yourself during your sick leave.

The aim of this examination is to check that you are able to return to your previous role. The occupational health doctor may, if necessary, set out restrictions, make comments or propose alterations to your role. Depending on your state of health, there are various different possibilities that may arise when you return to work:

- You have made a good recovery and can return to work in the same way as you did before your illness.
- You don't feel like you are completely back to full health and you want to return to work gradually. In this case, a **gradual return to work for therapeutic reasons (*reprise progressive du travail pour raisons thérapeutiques*/RPTRT)** may be the best option for you.
- You will return to work with adjustments made to your role.
- You can no longer fulfil the role you had before your illness for health reasons. In this case, the **(internal/external) professional redeployment** process will be initiated by the CMSS.
- You may no longer be able to work (see section on Disability and specific needs p. 59)

La reprise progressive du travail pour raisons thérapeutiques (RPTRT)

This measure has replaced the previous one on **part-time work for therapeutic reasons**. Since 2019, a new law has been in place, which provides more personalised options for returning to work that can be tailored to the specific state of health of the person in question and is therefore more flexible than in the past.

To take advantage of this measure, you must meet the following conditions:

1. Your primary doctor needs to complete the standard Request for a gradual return to work for therapeutic reasons form.
2. You must be unable to work at the time the request is made. Moreover, you must have been unable to work for at least one month during the three months prior to the request.
3. Your employer must agree. You should send the duly completed form to your employer, who will confirm their approval by signing it.
4. You should then send the request to the CNS and the CMSS will make a decision on your request.
5. You will receive the decision in writing at your home address.

The gradual return to work for therapeutic reasons can only begin once the CMSS has approved it.

Useful info

During your gradual return to work, **you are on sick leave**. You should present a medical certificate confirming your incapacity for work for this period. During this measure, you will receive sickness benefits and these will be included when calculating the 78-week rule.

Return to work with adjustments to your role

You may return to work but your role could be adjusted to suit your abilities – this is what is known as a **return to work with adjustments to your role**. For instance, you may be excused from night shifts if your role used to involve shift work.

Indeed, your employer needs to let the occupational health doctor know if you return to work after an absence of over six weeks. The doctor may conduct a medical examination in order to assess your ability to return to your previous role. This examination assessing your ability to return to work must be carried out before you return to work or no later than the day you return.

You can request this examination yourself by contacting the occupational health doctor. Depending on the results of the assessment, the occupational health doctor may recommend adjustments to your role. If your employer agrees with these adjustments, you can return to your role with these changes in place.

During a subsequent assessment, which will be arranged by the occupational health doctor, other measures may be taken depending on your state of health and your capacity for work.

Professional redeployment (internal/external)

If you are no longer able to carry out your previous role for health reasons, the **(internal/external) professional redeployment** process will be set in motion by the CMSS.

The CMSS will assess your situation so that it can direct you to the most suitable support system. If it is deemed that you are no longer able to carry out your previous role, the CMSS shall refer the case to the joint committee *(la commission mixte)* and the occupational health doctor responsible.

- If the occupational health doctor decides that you are able to carry out your previous role, the joint committee will not approve a redeployment.
- If the occupational health doctor decides that you are no longer able to carry out your previous role, the joint committee will make a decision regarding an internal or external professional redeployment.
- You will be informed of the joint committee's decision by registered letter within 15 working days. You can appeal this decision within 40 days by informing the social security arbitration board (*Conseil arbitral de la sécurité sociale*/CASS)

Following the referral to the joint committee, you will receive special protection against dismissal, except in the event of gross misconduct. This protection shall expire at the end of the 12th month following the notification to the employer of the decision to proceed with the mandatory internal professional redeployment.

Internal redeployment (within the same company) is enacted with your current employer. The occupational health doctor will provide opinions on:

- Your ability to work;
- Any possible reduction in working hours or performance;
- Any adjustments to your role;
- The temporary or permanent nature of your incapacity for work;
- The time frame within which you need to have a reassessment.

External redeployment (outside your company) occurs across the wider labour market. In this case, you are registered as a job seeker with the agency for employment development (*Agence pour le développement de l'emploi*/ADEM) and you can request unemployment benefit. If you have not found a new job after the period for the payment of unemployment benefit has expired (including any renewals), under certain conditions (the occupational health doctor confirms your capacity to carry out your previous profession for at least ten years or if you carried out a profession for at least ten years) you may request transitional professional payment, providing that you remain registered as a job seeker.

If the new job results in a lower salary, you are entitled to a compensation payment until the time when your current salary is no longer lower than your salary before your illness and rehabilitation prior to returning to work.

If you have the status of a person subject to professional redeployment, you reach the end of your unemployment benefit and under certain conditions (you had a seniority of at least five years in a role before redeployment, or a seniority of at least five years in the company subject to the external professional redeployment decision),

you may receive a professional transition allowance (***indemnité professionnelle d'attente*/IPA**). This is capped at 1.5 times the minimum wage and subject to social contributions and taxes. The IPA is granted, withdrawn and paid by the ADEM.

Please note: requests for the professional transition allowance must be submitted **within six months** from the end of your unemployment rights.

ADEM disability and professional redeployment department – *Service handicap et reclassement professionnel de l'ADEM*
T 247-88 888
E via a contact form

Do I need to mention my illness at job interviews?

Illnesses are by their very nature a very personal thing and relate to the most private, intimate areas of your life. As a result, if you have overcome cancer and are invited to attend an interview, you do not need to mention your illness. However, remember that when you sign an employment contract, you must agree to a pre-hiring medical examination being carried out by the occupational healthcare professional. The purpose of this examination is to check whether you have the abilities required to perform the role and whether the employment contract can be validated.

What should I know if I am unlikely to be able to return to work?

If you are on long-term sick leave and are unlikely to be able to return to work, you should identify the most appropriate social security cover for your situation as soon as possible and go through the necessary processes. If you are unable to work for an extended period, you will usually be invited to have a medical examination carried out by the CMSS after six weeks.

Remember that the classification applied to your circumstances is often not determined at the first medical examination conducted by the CMSS (after six consecutive weeks of sick leave) and it depends on how your illness and treatment develops. What is critical is ensuring that the steps necessary to ensure you have suitable social security cover are taken before you reach the total of 78 weeks.

On your side, pay close attention to the number of days you have accumulated towards the 78-week total. If you notice that your incapacity for work is moving you closer to the 78-week limit (whether consecutive or episodic) and that after the first medical examination, you have not received an invitation from the CMSS for a new assessment, you can book an appointment yourself with the relevant occupational health professional. They can assess your situation regarding your fitness to work in light of your illness and put measures in place, where necessary.

Managing cancer at work

Getting a cancer diagnosis impacts every aspect of your life, including your career.

Developing a strategy and taking the time to think about the information you are going to give to your employer and/or your colleagues and how you will do it can help you overcome this challenge. Prepare yourself to be faced with a wide range of reactions and emotions.

Should I let my employer and/or my colleagues know about my diagnosis?

To prepare yourself, talk to the medical team treating you to get all the information you need about your state of health, the prognosis and the way your treatment may affect your ability to work. Bear in mind that this may change during and after your treatment.

You are in no way obliged to go into detail about your diagnosis and treatment with your employer. However, maintaining a transparent dialogue with your employer can help them understand the support you need, especially in terms of reasonable adjustments and alterations that could make your life easier at work.

Who should I inform at work and how should I do it?

It is up to you whether you wish to inform your employer straight away about your illness or not. A cancer diagnosis is a difficult thing to talk about and it is understandable that you feel uncomfortable about it or afraid to reveal the state of your health to your employer and/or your colleagues. On the other hand, your boss/line manager and your colleagues can offer you considerable support.

The nature and scope of information to give and request

What you tell your employer about your diagnosis depends on various factors, including the nature of your relations and the potential impact of your treatment on your health and safety, and that of your colleagues. Bear in mind that informing your employer about your diagnosis does not mean that your colleagues also need to be told. Your line manager, boss or employer does not have the right to use your medical information, or disclose it to others, unless you give them your explicit consent to do so.

If you decide to give people information, you might want to mention:

- Your symptoms;
- Your diagnosis;
- The nature of your treatment, possible side effects and their potential effects on your physical health, mental well-being and, in particular, your diligence, productivity and performance;

- Any leave you may need to take and the likely date of your return to work based on the information you have.

You could also consider getting information about:

- Possible adjustments, additional breaks (due to pain or fatigue, or to attend medical appointments), shorter hours, remote working, part-time working, changes to your workstation (e.g. a special chair, an adjustable desk or ergonomic work tools) or any other requirement you may have;
- The support you might receive to help you do your job and complete the tasks assigned to you;
- The benefits you are entitled to, the rights of employees and the company policy on sick pay, sick leave, occupational health, support schemes, etc.

Before you speak to your employer about your diagnosis for the first time, it is a good idea to note down what you want to say. It is also advisable to note down before any meeting with your employer any question or concern you have and after the meeting note down any adjustments to your working practices you agreed with your employer.

Working during treatment

Your ability to work while undergoing treatment will depend on various factors, such as the recommendations of the medical team treating you, the type and stage of cancer in question, the type of treatment you will receive and the side effects, your general condition and personal choices, the type of work you do, and your company's policy on daily allowances, sick leave and occupational health.

How can I tell my employer that I am able to continue working during my treatment if my doctor advised me that I can?

If your doctor tells you that you can continue working during your treatment and you agree, you can speak to your employer and/or the human resources department (where applicable) about the options that would allow you to find a balance between working and undergoing treatment.

Returning to work after treatment

When your treatment is over and you feel ready to return to work, find out about the relevant rules and policies that may make your full return to work easier.

Your team, line manager and bosses may not be forthcoming when it comes to your return to work. Take the initiative and tell your bosses, line managers and colleagues how they can help make your return a success.

Here are some recommendations to help you prepare your return to work after your treatment:

- Let your employer know as soon as possible about your plans to return to work and inform your boss/line manager about your state of health and any lingering side effects that may affect you (e.g. fatigue, pain, difficulty concentrating without breaks, reduced mobility, etc.);
- If you are unsure whether you will be able to make a full return to work, speak to your boss/line manager about what temporary adjustments and changes may be possible (e.g. reduced or adjusted tasks, adjustments to workstation, gradual return to work, modified job description, part-time working, etc.);
- Speak about your concerns and explain what is working well and what needs adjusting at work during regular meetings with your boss/line manager;
- Take the time to look after yourself to reduce your stress as much as possible and return to work in the best possible conditions (e.g. ensure you have a healthy, balanced diet, do regular exercise, get rest after work, etc.).

Fondation Cancer can provide you with a guide for employees with all the information you need on managing cancer in the workplace.

Unemployment

If you are unemployed but able to work, you can claim unemployment benefit. However, you must meet certain conditions.

I've lost my job. What conditions do I need to meet to be entitled to unemployment benefit?

If you are unemployed, you can submit a claim for unemployment benefit as soon as you are capable of working again and are no longer receiving sick pay.

Preconditions for receiving unemployment benefits:

- You lost your job in circumstances beyond your control (involuntary unemployment);
- You are registered as a jobseeker with ADEM;
- You are at least 16 and no older than 64;
- You are not receiving disability benefit, an old-age pension or accident-related benefit;
- You must be able to work, be available to work and be prepared to accept any suitable job;
- You worked as an employee for at least 26 weeks (for at least 16 hours per week) over the 12 months prior to being registered as a jobseeker;
- You live in Luxembourg.

Amount of unemployment benefit

Unemployment benefit is paid at 80 % of the amount of your last gross salary. If you have one or more dependent children, this rate is increased to 85 %. Unemployment benefit may not exceed the equivalent of 2.5 times the minimum wage (*salaire social minimum*/SSM). This cap will reduce gradually as the benefit payments continue. In this case, this cap gradually reduces as follows:

- After six months of unemployment, the cap is reduced to 2 times the minimum wage;
- After 12 months, the cap is reduced further, to 1.5 times the minimum wage. This applies to jobseekers who obtain an extension to their unemployment benefit beyond 12 months.

Duration of unemployment benefit

The duration of the unemployment benefit depends on the amount that the jobseeker has worked during the 12-month reference period. This benefit can last for up to 12 months.

E.g.: If, during the 12 months prior to the day you register as a jobseeker, you worked for seven months and 21 days, you will receive unemployment benefit for eight months.

However, depending on the circumstances, it is possible to get an extension by making a request to ADEM, if:

- You are over 50

- You have contributed to the pension fund for 20, 25 or 30 years,

the length of time that unemployment benefit can be paid out can be extended (+12 months/+9 months/+6 months), but the overall duration cannot exceed 24 months.

Information and contacts

ADEM
Opening hours: Monday to Friday, 8am-midday and 1pm-5pm
T 24 78 88 88
E via a contact form

Disability and specific needs

If you are unable to work for health reasons, you can claim disability benefits, so it is good to know what conditions apply and what rights you have. Anyone who, following an extended illness, has lost the capacity to work insofar as they are unable to do the job they did previously or another job in line with their strengths and abilities is considered to be suffering from a disability.

I can no longer work due to health reasons. Will I receive disability benefits?

In this case, your level of disability will be assessed. After submitting your claim to the national pension insurance fund (*Caisse nationale d'assurance pension*/CNAP), you will be assessed to find out whether you will receive temporary or permanent disability benefits. The amount of the disability benefits is calculated according to your salary and the number of years you have worked.

Conditions for receiving disability benefits:

- You must have been insured for at least 12 months during the last three years prior to the date on which your disability began;
- You must not have reached normal retirement age (65 years).

Can I work part-time even if I'm receiving disability benefits?

If you return to paid work, you must let the relevant benefits organisation know immediately, because if disability benefits are being received at the same time as a salary and pay, the disability benefits you receive may be reduced.

Useful info

- The annual income from this professional activity must not exceed one third of the annual minimum wage.
- If you return to self-employed work subject to mandatory insurance, the disability benefits are withdrawn.

Information and contacts

National Pension Insurance Fund – Caisse nationale d'assurance pension (CNAP)
T 22 41 41 1
F 22 41 41-64 43
E via the website

When can I ask for financial support in addition to the disability benefits?

If your disability benefits are below the social minimum threshold set by the amount of the social inclusion income (*revenu d'inclusion social*/REVIS) €1,802.45 gross for an adult, (as of 09.2023) and if you meet the preconditions, you can claim additional financial support in the form of

the REVIS/inclusion benefit. You can apply directly to the National Solidarity Fund (*Fonds national de solidarité*/FNS). Book an appointment with your local social services to help you make your application.

Contact

FNS National Solidarity Fund – *Fonds national de solidarité*
T 49 10 811
F 26 12 34 64
E info@fns.public.lu

Disability cards – what do I need to know?

If you have a disability level of at least 30%, you can apply for a disability card.

There are three categories of card:

- Category A disability card: for people whose physical disability level is between 30% and 49%;
- Category B disability card: for people whose physical disability level is above 50%. These people have priority rights for access and services, as well as a guaranteed seat in all circumstances;
- Category C disability card: for people whose physical or mental conditions means that they need assistance to get around.

With card C, all the rights that a category B cardholder enjoys are transferred to the person providing assistance. Category B and C disability cards allow you full tax exemption on motor vehicles.

You can make an application by filling in a duplicate copy form with two recent ID photos and sending it to your local authority.

What conditions do I need to meet to get a priority access card (parking badge) which allows me to use disabled parking spaces?

To get a disabled parking badge, you must meet the following conditions:

- You have had your disability for at least six months and be unable to walk unaided for more than 100m, with or without a break;
- You need crutches or a wheelchair to move around;
- Or you are blind.

You need a photo ID and a specific form that you can request or download from the Ministry of Sustainable Development and Infrastructure *(Ministère du Développement durable et des Infrastructures)*.

Your primary doctor must confirm your disability on the back of the form.

You can then send the completed form with the photo ID attached to the Transport Department at the Ministry of the Environment, Climate and Sustainable Development at the following address

Ministère de l'Environnement, du Climat et du Développement durable
Département des transports
L-2918 Luxembourg

What do I need to know about the disabled employee status?

Reduced capacity for work can result from a physical, mental, sensory or psychological disability and/or psychological and social difficulties. Concepts of reduced capacity for work and disability are often used as synonyms when it comes to illnesses and work.

To obtain disabled employee status, you must demonstrate a reduction in your capacity for work of at least 30 % and you also need to have a stable medical condition. You must not have already started the disability procedure.

If you receive disabled employee status, you can benefit from support, including:

- Training and professional transition support;
- Adjustment to your workplace;
- Six additional days of leave.

Information and contacts

ADEM Professional support and redeployment committee – *Commission d'orientation et de reclassement professionnel*
T 247-88 888
E via a contact form

What do I need to know about the disabled workers allowance (RSH)?

If you are unable to work as a result of your cancer, you can claim disabled workers allowance. To do this, you need to meet a number of conditions

- You have a recognised disability;
- You have disabled employee status
- For reasons beyond your control, you are unable to find a job that meets your requirements;
- You live in Luxembourg, you are over 18 and under 65;
- Your income is lower than the RSH.

Subject to these conditions and as soon as you no longer receive unemployment benefits, you can register with ADEM as a disabled employee looking for a job.

To ensure you have financial support while you are looking for a job, you can apply for the RSH.

IV. Disputes and insurance

In the event of disputes

If you believe that your rights as a patient have not been respected, you should first and foremost try to establish a dialogue with the person or institution in question. If an amicable settlement is not possible, you can dispute a decision or pursue legal action.

Advice and support are available from the following services:

National healthcare information and mediation service – *Service national d'information et de médiation dans le domaine de la santé*
T 24 77 55 15
E info@mediateursante.lu

Patiente Vertriedung
T 49 14 57 1
E info@patientevertriedung.lu

I believe my rights have been infringed by a decision made by a social security body. What do I need to know about the legal procedures and relevant courts for social security matters?

Various legal options are open to you in this case. Relevant addresses are provided in section V. Useful addresses p. 68.

If you disagree with a decision taken by the CMSS, the CNS, or other similar bodies, you must first submit an objection in writing by registered mail within the time frame indicated on the notice. You do not need to consult a solicitor to do this. In this letter, you are asking the institution in question to review the decision taken.

In the event of problems regarding healthcare costs/bills, you can contact the social security monitoring board *(Commission de surveillance de la sécurité sociale)*.

Social Security Monitoring Board
Ministry of Social Security Monitoring Board – *Commission de surveillance de la sécurité sociale*
Ministère de la sécurité sociale
Commission de surveillance
T 24 78 63 85

You can subsequently file an official complaint with the social security arbitration board (*Conseil arbitral de la sécurité sociale*/CASS). You do not need to consult a solicitor to do this. The CASS makes rulings on all complaints up to a dispute value of €1,250.

Social Security Arbitration Board – *Conseil arbitral de la sécurité sociale* (CASS)
T 45 32 86 600
F 44 32 66

You can oppose a ruling from the CASS by launching an appeal with the High Council of Social Security (*Conseil supérieur de la sécurité sociale*/CSSS) if the value of the dispute is greater than €1,250. You do not have to use the services of a solicitor to do this.

High Council of Social Security – *Conseil supérieur de la sécurité sociale* (CSSS)
T 26 26 05 1
F 26 26 05 38

As a last resort, you can oppose the rulings of the above authorities by appealing to the Court of Cassation *(Cour de cassation)*. You need a solicitor to undertake this process.

You can also contact the Ombudsman.

Ombudsman Luxembourg
T 26 27 01 01
E info@ombudsman.lu

I'm having problems receiving my unemployment benefits. Who should I contact?

If you are having problems with your unemployment benefits (e.g. your claim has been rejected), you can request that your case be reviewed by ADEM's Special Review Board *(Commission spéciale de réexamen de l'ADEM)* within 40 days.

ADEM Special Review Board – *Commission spéciale de réexamen*
T 247-88 888

I am in a dispute with my employer. Who can I contact?

If you disagree with a decision your employer has taken, you can ask for support from your staff representative or your union. You can also get help and support from the Inspectorate of Labour and Mines (*Inspection du Travail et des Mines*/ITM).

The ITM is responsible for monitoring the application of employment law (regulatory working conditions, safety measures, etc.) and preventing or mediating disputes in the workplace.

It can take legal action against your employer with penalties ranging from a warning to the closure of the company. It can also pass on the case to the public prosecutor for criminal proceedings.

If you have questions or want to book an appointment:

Inspectorate of Labour and Mines – *Inspection du Travail et des Mines*
T 247-76100
E via contact form

If your problem falls outside the remit of the ITM, it will direct you to the National Conciliation Service *(Office national de conciliation)*.

Legal issues: advice and assistance

This section sets out all the information you may need to get free legal advice and/or assistance.

Do you need legal advice?

The Legal Reception and Information Service (*Service d'accueil et d'information juridique*/SAIJ) provides information and advice on legal issues free of charge but cannot represent you. It may, where applicable, direct you towards other sources of assistance.

Its offices are located in Luxembourg City and Diekirch. You can visit the branch of your choice.

Legal Reception and Information Service – *Service d'accueil et d'information juridique* - Luxembourg City
T 47 59 81 – 2600 (appointment bookings)
E pgsin@justice.etat.lu

From Monday to Friday. 8:30am-midday and 1pm-4:30pm, on appointment only, except Mondays.

The information service provided by solicitors is open every Saturday morning from 8:30am-12:30pm (including judicial holidays).

It is strongly recommended that you visit the news page to check that the service is open before setting off.

Legal Reception and Information Service – *Service d'accueil et d'information juridique* - Diekirch
Palais de justice de Diekirch -
Salle d'audience II EG21
T 80 23 15
E pgsin@justice.etat.lu

Every Wednesday, from 9am-11:30am and 2:30pm-5pm, no appointment needed.

I need the services of a lawyer, but I cannot afford the fees. What can I do?

If you need **a lawyer to represent you**, but you cannot afford the fees, you can request free legal assistance. To do so, you need to complete a form for your free legal assistance request.

You can also get the form at the offices of both judicial districts.

You should then send the request to the relevant judicial district based on your location (Luxembourg or Diekirch).

For Luxembourg City, the duly completed form and required documents should be sent to aj@barreau.lu or submitted to the legal assistance office.

Legal assistance office – *Service de l'assistance judiciaire*
T 46 72 72-1

Open for the submission of documents: Monday to Thursday 9:30am-11:30am.

For Diekirch, the duly completed form and required documents should be sent to info.diekirch@barreau.lu.

Diekirch Legal District - Diekirch Bar Association – *Arrondissement judiciaire de Diekirch - Bâtonnier de l'Ordre des Avocats de Diekirch*
E info.diekirch@barreau.lu

Outstanding balance insurance/The right to be forgotten

In principle, if you want to get a mortgage from a bank, you need to take out outstanding balance insurance with an insurance company. This insurance guarantees repayment of a mortgage in light of certain risks and is often a condition for getting a mortgage approved. However, people with increased health risks have to pay a surcharge in the form of an additional premium.

For some people affected by cancer, this surcharge can be so high that they end up being unable to afford to take out a mortgage. This can be the case even if people have long recovered from cancer or if their cancer is only at an early stage.

The principle of the right to be forgotten

The Right to be forgotten allows you to no longer be obliged to declare a cancer that you had at some point in the past. This is a right for anyone wishing to take out a borrower's insurance contract to guarantee a mortgage for a primary residence, meaning that they do not have to declare a previous cancer diagnosis after a certain time period. This applies:

- Only to outstanding balance insurance (explicitly excluding disability and incapacity cover);
- Only for a loan or mortgage to buy a primary residence or business premises and;
- Only when the maximum amount of the outstanding balance insurance does not exceed €1,000,000. It does not apply if you are buying a secondary residence or investing in property with the intention to rent it out.

In addition, the potential policyholder must also be under 70.

Right to be forgotten with no obligation to declare

In practice, when you apply for outstanding balance insurance for a mortgage:

- The insurance applicant is entitled not to declare their cancer provided that the cancer treatment process was completed **over ten years ago**; (five years for cancer diagnosed before the age of 18) and **without any relapses**.
- Insurance companies undertake that no medical information regarding cancer is taken into account when accepting the risk and calculating the premiums for the outstanding balance insurance, providing that the cancer treatment was completed over ten years ago and without any relapses. (This is also the case for cancers diagnosed up until the age of 18, but the treatment for which was completed over five years ago, without any lapses).

Right to be forgotten with an obligation to declare

There is a list containing various cancers *(grille de référence (partie I))*, which supplements the provisions setting out the right to be forgotten. This list is based on the French reference grid of 16 July 2018.

When you apply for outstanding balance insurance for a mortgage, you must declare if you have recovered from one of the specific types of cancer (in a list of ten), but if you meet certain conditions, the insurer cannot exclude you from cover or apply a surcharge.

In this case, you will benefit from a shorter qualifying period for outstanding balance insurance, without any surcharges (less than ten years, or five years where applicable, after the end of the treatment without any relapses).
If the conditions are met, no medical information about your cancer will be taken into account when assessing your access to insurance and the calculation of premiums for the outstanding balance cover.

Useful info

The completion of your treatment is defined as: *"the date on which active treatment for your cancer, including surgery, radiotherapy and chemotherapy, in authorised institutions, ends, with no relapses, after which no further treatment is necessary, apart from possible ongoing therapy such as hormone therapy and immunotherapy"*.

A relapse is defined as: *"any new medically observable sign of cancer, whether detected via a clinical or biological examination or medical imaging."*

V. Useful addresses

National Healthcare Fund – *Caisse nationale de santé* (CNS)
4, rue Mercier
L-2144 Luxembourg-Gare
Postal address: L-2980 Luxembourg
T 27 57-1
E via a contact form

Healthcare fund for civil servants and municipal employees – *Caisse de maladie des fonctionnaires et employés communaux* (CMFEC)
20, avenue Emile Reuter
L-2420 Luxembourg
Postal address: B.P. 328
L-2013 Luxembourg
T 45 05 15

Healthcare fund for civil servants and public employees – *Caisse de maladie des fonctionnaires et employés publics* (CMFEP)
32, avenue Marie-Thérèse
L-2132 Luxembourg
T 45 16 81
E cmfep@secu.lu

National Pension Insurance Fund – *Caisse nationale d'assurance pension* (CNAP)
1, boulevard Prince Henri
L-1724 Luxembourg
T 22 41 41 1
T 224141-6500
E via website

Mutual healthcare assistance of the national railway company of Luxembourg – *Entraide médicale de la société nationale des chemins de fer luxembourgeois* (EM-CFL)
2B, rue de la Paix
L-2312 Luxembourg
T 49 90 - 3416

Social Security Medical Inspectorate – *Contrôle médical de la sécurité sociale* (CMSS)
4, rue Mercier
L-2144 Luxembourg-Gare
B.P. 1342 L-1013 Luxembourg
T 24 76 75 00

High Council of Social Security – *Conseil supérieur de la sécurité sociale* (CSSS)
14, avenue de la Gare
L-1610 Luxembourg
T 26 26 05 1
F 26 26 05 38

Social Security Arbitration Board – *Conseil arbitral de la sécurité sociale* (CASS)
271, route d'Arlon
L-1150 Luxembourg

Insurance assessment and monitoring unit – *Administration d'évaluation et de contrôle de l'assurance* (AEC)
4, rue Mercier
L-2144 Luxembourg-Gare
T 247-86 060
F 247-86 061
E secretariat@ad.etat.lu

Accessory Equipment Service – Service Moyens Accessoires (SMA)
22-22, rue Geespelt
L-3378 Livange
T 40 57 33 1
F 40 95 17
Msg 621 340 257
E contact@sma.lu

Agency for Employment Development – *ADEM*
3a, rue de Bitbourg
L-1273 Luxembourg
T 24 78 88 88
E via a contact form

Inspectorate of Labour and Mines – *Inspection du Travail et des Mines* (ITM)
3, rue des Primeurs
L-2361 Strassen
T 247-76100
E via website

National Solidarity Fund – *Fonds national de solidarité* (FNS)
8-10, rue de la Fonderie
L-1531 Luxembourg
Postal address: B.P. 2411
L-1024 Luxembourg
T 49 10 811
F 26 12 34 64
E info@fns.public.lu

National healthcare information and mediation service – *Service national d'information et de médiation dans le domaine de la santé*
11 Rue Robert Stumper,
L-2557 Gasperich Luxembourg
T 24 77 55 15
E info@mediateursante.lu

Patiente Vertriedung
1B, rue Thomas Edison
L-1445 Strassen
T 49 14 57 1
E info@patientevertriedung.lu

Ombudsman Luxembourg
36, rue du Marché-aux-Herbes
L-1728 Luxembourg
T 26 27 01 01
E info@ombudsman.lu

Emile Mayrisch Hospital –
Centre Hospitalier Emile Mayrisch
(CHEM)
Rue Emile Mayrisch
L-4240 Esch-sur-Alzette
T 57 11 1

Luxembourg City Hospital –
Centre Hospitalier de Luxembourg **(CHL)**
4, rue Ernest Barblé
L-1210 Luxembourg
T 44 11 11

CHL Eich
L-1460 Luxembourg
T 44 11 12

Kirchberg Hospital –
Hôpital Kirchberg **(HRS)**
9, rue Edward Steichen
L-2540 Luxembourg
T 24 68 1

ZithaKlinik (HRS)
20-30 rue d'Anvers
L-1130 Luxembourg
T 28 88 1

Hospital du Nord –
Centre Hospitalier du Nord **(CHdN)**
120, avenue Salentiny
L-9080 Ettelbruck
E chdn@chdn.lu
T 81 66 1

Centre François Baclesse –
Centre National de Radiothérapie **(CFB)**
Rue Emile Mayrisch
L-4005 Esch/Alzette
T 26 55 66 1

Haus Omega
80, rue de Hamm
L-1713 Luxembourg
E info@hausomega.lu
T 26 00 37 1

HELP – Doheem Versuergt
11 Place Francois-Joseph Dargent
L-1413 Luxembourg
E info@help.lu

Päiperléck S.à.r.l.
1b, rue Stohlbou
L-6181 Gonderange
E info@paiperleck.lu

Stëftung Hëllef Doheem
48a, avenue Gaston Diderich
L-1420 Luxemburg
E info@shd.lu
T 40 20 80

The Château de Colpach rehabilitation centre – *Centre de réhabilitation du Château de Colpach*
1, Am Schlasspark
L-8527 Colpach-Bas
T 27 55 43 00
E crcc@croix-rouge.lu

Family support

Familljenhaus Zentrum
29, rue de Mamer
L-8081 Bertrange
T 40 49 49 400
F 40 21 31 339

Mondorf Domaine Thermal
Avenue des Bains
B.P. 52
L-5601 Mondorf-les-Bains
T 23 666-800
F 23 666 -557
E domaine@mondorf.lu

Ministry of Labour, Employment and the Social Economy – *Ministère du Travail, de l'Emploi et de l'Économie sociale et solidaire*
26, rue Sainte-Zithe
L-2939 Luxembourg
T 2478-6130

Customs and Excises Office (Directorate) – *Administration des douanes et accises (Direction)*
22, rue de Bitbourg
L-1273 Luxembourg
T 28 18 28 18 (switchboard)

Transport Department at the Ministry of the Environment, Climate and Sustainable Development – *Ministère de l'Environnement, du Climat et du Développement durable Département des transports*
4, place de l'Europe
L-1499 Luxembourg

Ministry of Social Security – *Ministère de la sécurité sociale*
26, rue Sainte Zithe
L-2763 Luxembourg

Legal Reception and Information Service – *Service d'accueil et d'information juridique* - Luxembourg City
Cité judiciaire - Bâtiment BC
L-2080 Luxembourg

Legal Reception and Information Service – *Service d'accueil et d'information juridique* - Diekirch
Palais de justice de Diekirch -
Salle d'audience II EG21
4, place Guillaume
9280 Diekirch

Legal assistance office – Service de l'assistance judiciaire
45, allée Scheffer
L-2520 Luxembourg

Diekirch Legal District - Diekirch Bar Association – *Arrondissement judiciaire de Diekirch - Bâtonnier de l'Ordre des Avocats de Diekirch*
B.P. 68
L-9201 Diekirch

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T 45 30 331
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